

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11045

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11018

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Mary land b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills, Maryland 1628-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 414 Carmody Hill Drive	
3. NAME OF DECEASED (Type or print) First Leo Middle Andrew Last Ackerman		4. DATE OF DEATH Month October Day 6 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Stave Mill	
11. BIRTHPLACE (State or foreign country) Madison, Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Nicholas Ackerman		14. MOTHER'S MAIDEN NAME Julianne Lux	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular accident; old DUE TO (c) Cerebral and generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 19 1960 , to Oct. 6 1960 , that (I) (we) last saw the deceased alive on Oct. 6 1960 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 10-6-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-8-60	
23c. NAME OF CEMETERY OR CREMATORY Balvary Memorial Park, Fairfax, Va.		23d. LOCATION (City, town, or county) (State) 1628-2 Va.	
24. FUNERAL DIRECTOR'S SIGNATURE David N. Brandt		25a. REC'D BY REGISTRAR Oct 10 1960	
ADDRESS 1628-2		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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OFFICE OF DEATH

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CERTIFICATE OF DEATH

11019
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3507 East Joppa Road		d. STREET ADDRESS 4615 Chatford Ave.	
3. NAME OF DECEASED (Type or print) Patricia Virginia Adams		4. DATE OF DEATH Month October Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1924
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Continental Can	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Zacharko		14. MOTHER'S MAIDEN NAME Helen Stec	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-18-9592	
17. INFORMANT Jerome J. Adams		Address 4615 Chatford Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno-carcinoma of Pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1 , 19 60 , to 10/21 , 19 60 , that I last saw the deceased alive on 10/21 , 19 60 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1211 NORTHERN PKWY. BALTO. 12, MD DATE SIGNED			
ACTUAL SIGNATURE Robert W. Gebhardt M.D.		PHYSICIAN'S NAME (Type) ROBERT W. GEBHARDT	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller, Inc. 2431 E. Chesa. St. Balto.		24a. REC'D BY REGISTRAR DATE OCT 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland, and that the same has been compared with the original and found to be a true and correct copy.

CERTIFICATE OF DEATH

11026

11026

1. NAME OF DECEASED JOHN DOE		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 10/15/1910		5. PLACE OF DEATH Baltimore, Md.		6. CAUSE OF DEATH Heart Disease	
7. OCCUPATION Clerk		8. MARITAL STATUS Married		9. PLACE OF BIRTH Baltimore, Md.	
10. FATHER'S NAME John Doe		11. MOTHER'S NAME Jane Doe		12. DATE OF BIRTH 10/15/1910	
13. PLACE OF BIRTH Baltimore, Md.		14. DATE OF DEATH 10/15/1910		15. PLACE OF DEATH Baltimore, Md.	
16. CAUSE OF DEATH Heart Disease		17. PLACE OF DEATH Baltimore, Md.		18. DATE OF DEATH 10/15/1910	
19. PLACE OF BIRTH Baltimore, Md.		20. DATE OF DEATH 10/15/1910		21. PLACE OF DEATH Baltimore, Md.	
22. CAUSE OF DEATH Heart Disease		23. PLACE OF DEATH Baltimore, Md.		24. DATE OF DEATH 10/15/1910	
25. PLACE OF BIRTH Baltimore, Md.		26. DATE OF DEATH 10/15/1910		27. PLACE OF DEATH Baltimore, Md.	
28. CAUSE OF DEATH Heart Disease		29. PLACE OF DEATH Baltimore, Md.		30. DATE OF DEATH 10/15/1910	
31. PLACE OF BIRTH Baltimore, Md.		32. DATE OF DEATH 10/15/1910		33. PLACE OF DEATH Baltimore, Md.	
34. CAUSE OF DEATH Heart Disease		35. PLACE OF DEATH Baltimore, Md.		36. DATE OF DEATH 10/15/1910	
37. PLACE OF BIRTH Baltimore, Md.		38. DATE OF DEATH 10/15/1910		39. PLACE OF DEATH Baltimore, Md.	
40. CAUSE OF DEATH Heart Disease		41. PLACE OF DEATH Baltimore, Md.		42. DATE OF DEATH 10/15/1910	
43. PLACE OF BIRTH Baltimore, Md.		44. DATE OF DEATH 10/15/1910		45. PLACE OF DEATH Baltimore, Md.	
46. CAUSE OF DEATH Heart Disease		47. PLACE OF DEATH Baltimore, Md.		48. DATE OF DEATH 10/15/1910	
49. PLACE OF BIRTH Baltimore, Md.		50. DATE OF DEATH 10/15/1910		51. PLACE OF DEATH Baltimore, Md.	
52. CAUSE OF DEATH Heart Disease		53. PLACE OF DEATH Baltimore, Md.		54. DATE OF DEATH 10/15/1910	
55. PLACE OF BIRTH Baltimore, Md.		56. DATE OF DEATH 10/15/1910		57. PLACE OF DEATH Baltimore, Md.	
58. CAUSE OF DEATH Heart Disease		59. PLACE OF DEATH Baltimore, Md.		60. DATE OF DEATH 10/15/1910	
61. PLACE OF BIRTH Baltimore, Md.		62. DATE OF DEATH 10/15/1910		63. PLACE OF DEATH Baltimore, Md.	
64. CAUSE OF DEATH Heart Disease		65. PLACE OF DEATH Baltimore, Md.		66. DATE OF DEATH 10/15/1910	
67. PLACE OF BIRTH Baltimore, Md.		68. DATE OF DEATH 10/15/1910		69. PLACE OF DEATH Baltimore, Md.	
70. CAUSE OF DEATH Heart Disease		71. PLACE OF DEATH Baltimore, Md.		72. DATE OF DEATH 10/15/1910	
73. PLACE OF BIRTH Baltimore, Md.		74. DATE OF DEATH 10/15/1910		75. PLACE OF DEATH Baltimore, Md.	
76. CAUSE OF DEATH Heart Disease		77. PLACE OF DEATH Baltimore, Md.		78. DATE OF DEATH 10/15/1910	
79. PLACE OF BIRTH Baltimore, Md.		80. DATE OF DEATH 10/15/1910		81. PLACE OF DEATH Baltimore, Md.	
82. CAUSE OF DEATH Heart Disease		83. PLACE OF DEATH Baltimore, Md.		84. DATE OF DEATH 10/15/1910	
85. PLACE OF BIRTH Baltimore, Md.		86. DATE OF DEATH 10/15/1910		87. PLACE OF DEATH Baltimore, Md.	
88. CAUSE OF DEATH Heart Disease		89. PLACE OF DEATH Baltimore, Md.		90. DATE OF DEATH 10/15/1910	
91. PLACE OF BIRTH Baltimore, Md.		92. DATE OF DEATH 10/15/1910		93. PLACE OF DEATH Baltimore, Md.	
94. CAUSE OF DEATH Heart Disease		95. PLACE OF DEATH Baltimore, Md.		96. DATE OF DEATH 10/15/1910	
97. PLACE OF BIRTH Baltimore, Md.		98. DATE OF DEATH 10/15/1910		99. PLACE OF DEATH Baltimore, Md.	
100. CAUSE OF DEATH Heart Disease		101. PLACE OF DEATH Baltimore, Md.		102. DATE OF DEATH 10/15/1910	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11020

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (1)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 707 W. Lexington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First L.		Middle AESTOR		Last October	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 23, 1896	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker				10b. KIND OF BUSINESS OR INDUSTRY Carpentry		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME William Henry Aestor			
14. MOTHER'S MAIDEN NAME Mary Ellen Hanafin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. 218-01-1690				17. INFORMANT Clinical Recored, VAH, Balto. 18, Md. FORT HOWARD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) BRONCHOGENIC CARCINOMA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 DAYS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Sept. 21 1960 to October 4 1960 , that (X) (we) last saw the deceased alive on October 4 1960 , and that death occurred at 8:35 AM , from the causes and on the date stated above.							
22a. SIGNATURE Joseph J. Cillo M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/4/60	
22c. PHYSICIAN'S NAME (Type) JOSEPH J. CILLO, M.D.				22d. ADDRESS VAH BALTIMORE, MD. FT HOWARD DIV			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-7-60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				ADDRESS Wm. Cook-Blight Funeral Home, 6009 Harford Rd. Balto. Md.		25a. REC'D BY REGISTRAR DATE OCT 7 '60	
25b. REGISTRAR'S SIGNATURE Wm. L. Kenna							

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CERTIFICATE OF ORIGIN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11042

CERTIFICATE OF DEATH

11021
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 56 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jessups Spring Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle R. Last Agle		4. DATE OF DEATH Month October Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1867
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 24 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Stauffer		14. MOTHER'S MAIDEN NAME Fredericka Freeburger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Regina Eberhart		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 540 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Probable ruptured Peptic Ulcer DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Hypertensive cardio vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 8, 19 60 , to October 9, 19 60 , that I last saw the deceased alive on October 8, 19 60 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main Street Reisterstown, Md.	
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.		DATE SIGNED 10-10-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12, 1960	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR OCT 13 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11048 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11022**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Baltimore 22			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7541 Westfield Road				d. STREET ADDRESS 1 7541 Westfield Road			
3. NAME OF DECEASED (Type or print) First RAY Middle BOWDEN Last ARGUST				4. DATE OF DEATH Month OCT Day 28 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 DEC 23			
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Rhems Manuf.		11. BIRTHPLACE (State or foreign country) Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Argust			
14. MOTHER'S MAIDEN NAME Margaret Fugill				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW II			
16. SOCIAL SECURITY NO. 198-16-8142		17. INFORMANT Address Mrs. Dolores L Argust (Above)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 days							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Jack C. Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-29-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 31 OCT 60		22c. NAME OF CEMETERY OR CREMATORY Garden of Faith			
22d. LOCATION (City, town, or county) (State) Baltimore Maryland		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Brooks Bradley Inc. Balt 22 Md.					
24a. REC'D BY REGISTRAR DATE NOV 1 '60		24b. REGISTRAR'S SIGNATURE Clarence S. Hanks					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11032

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Smith		Male		45		Jan 15, 1900		New York, N.Y.	
Residence		Occupation		Cause of Death		Manner of Death		Place of Death	
123 Main St., Baltimore, Md.		Teacher		Heart Disease		Natural		Home	
Date of Death		Time of Death		Physician		Hospital		Burial Place	
Jan 20, 1945		10:30 A.M.		Dr. J. H. Jones		St. Mary's Hospital		Catholic Cemetery	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11035
11023
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7303 Dunbrook Court		d. STREET ADDRESS 7303 Dunbrook Court	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARION Middle FRANCES Last ATEN		4. DATE OF DEATH Month October Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1912
9. AGE (In years lost birthday) 48 yrs.	IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry L. Kletchka		14. MOTHER'S MAIDEN NAME Marion Hunderfund	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 063-01-6370	
17. INFORMANT Maurice Aten 7305 Dunbrook Court		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral CA of Both Ovaries DUE TO 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) with Cerebral Metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 4 19 60 to Oct. 24 19 60 that (I) (we) last saw the deceased alive on Oct. 18 19 60 , and that death occurred on Oct. 24 19 60 , from the causes and on the date stated above.			
22a. SIGNATURE M.B. Davis M.D.		22b. DATE SIGNED Oct. 24, 1960	
22c. PHYSICIAN'S NAME (Type) M.B. Davis, M.D.		22d. ADDRESS Dundalk - 22 - Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Oct. 25, 1960	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town, or county) (State) Brooklyn, N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md,		25a. REC'D BY REGISTRAR DATE OCT 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

11038

RECEIVED

11038

CHIEF T.M.P.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1, 7 Film G274 11-4-60 et

11024

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY in 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) --		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 912 DULANEY VALLEY COURT			
3. NAME OF DECEASED (Type or print) ERWIN THEODORE BACKUS		4. DATE OF DEATH Month October Day 27 Year 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1884	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY OWNER BACKUS MOTORS		11. BIRTHPLACE (State or foreign country) DETROIT MICH.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address MR. PAUL R. HASSENCAMP TITLE BLDG.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (b) Myocardial Infarct. (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William V. Lovitt, Jr.		EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED October 28, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/31/60		22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	
22d. LOCATION (City, town, or country) BALTIMORE, MD.		23. FUNERAL DIRECTOR H. M. Meador Address 505 N. Calvert St.			
24a. REC'D BY REGISTRAR OCT 31 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

11032

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TO TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11050

11025

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosewood State Training School</u> c. LENGTH OF STAY IN 1b <u>OWINGS MILLS MD.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>85 X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEYSER - W. VA.</u> d. STREET ADDRESS <u>ROUTE #3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KEITH</u> Middle <u>WAYNE</u> Last <u>BARB</u>		4. DATE OF DEATH Month <u>10-22-</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>KEYSER. W. VA.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harding Loyal Barb</u>		14. MOTHER'S MAIDEN NAME <u>Dora Catherine Tser Barb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Medical Record, Rosewood State Training School</u>	
17. INFORMANT <u>Medical Record, Rosewood State Training School</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congenital cerebral defect.</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/24/56</u> 19 <u>56</u> to <u>10/22/60</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10/22</u> 19 <u>60</u> and that death occurred <u>10 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Hea Rankew</u>		22b. DATE SIGNED <u>10-22-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hea Rankew MD</u>		22d. ADDRESS <u>Rosewood State Training School, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/23/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WAXLEY</u>		23d. LOCATION (City, town, or county) (State) <u>ALLEGHENY CO. MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>North & Pa. Ave. - Balto. 17. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>William J. Kline</u>	

11082

11081

OFFICE OF CHAIR

W. V. A.

W. V. A.

W. V. A.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11026

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6728 Danville Avenue				d. STREET ADDRESS 6728 Danville Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DORIS Middle LUCILLE Last BELCASTRO				4. DATE OF DEATH Month October Day 8 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-1912			
9. AGE (In yrs. mo. da.) 48 yrs.		IF UNDER 1 YEAR Months 4 Days 11		IF UNDER 24 HRS. Hours 11 Min. 00					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel W. Hanns				14. MOTHER'S MAIDEN NAME Nora France					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 233-09-4333		17. INFORMANT John S. Belcastro (Above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 10/10/60	
EXAMINER'S NAME (Type) M. B. Davis M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc.				ADDRESS Balt 22 Md.		24a. REC'D BY REGISTRAR OCT 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6274 11-3-60 et

11051

CERTIFICATE OF DEATH

Reg. Dist. No.

11027

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,		c. LENGTH OF STAY IN 1b 55 Towson 4,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 318 E. Pennsylvania Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marshall First Bell Last		4. DATE OF DEATH October Month 27 Day 1960 Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1890
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Private Homes	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sandy Bell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 912-10-8928	
17. INFORMANT Marie Bell - 318 E. Pa. Ave. Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL EMBOLISM - JAN 1960		INTERVAL BETWEEN ONSET AND DEATH 2 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 1 , 19 58 , to OCT 27 , 19 60 , that I last saw the deceased alive on OCT 20 , 19 60 , and that death occurred at 4:10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 10/28/60 DATE SIGNED	
ACTUAL SIGNATURE T. C. Siwinski M.D.			
PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski, M.D.		206 W. Pennsylvania Ave., Towson 4, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/60	
22c. NAME OF CEMETERY OR CREMATORY pleasant rest		22d. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Chatman Jr. - 1701 Mt. Culler St. Balto. Md.		ADDRESS	
24a. REC'D BY REGISTRAR OCT 31 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

11051

John J. Jones

John J. Jones

John J. Jones

John J. Jones

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11028

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Manor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Manor</u>			
c. LENGTH OF STAY IN 1b <u>13 yrs.</u>				d. STREET ADDRESS <u>1326 Lafayette Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1326 Lafayette Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>F.</u> Last <u>Berger</u>				4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1896</u>	
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Louis F. Berger, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Lena Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>217-24-7124</u>			
17. INFORMANT <u>Mildred I. Berger</u>				Address <u>1326 Lafayette Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO (b) <u>Antenatal C-V Damage</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10+ yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Passive Congestion - Failure of Circulation</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>8/19/55</u> 19 <u> </u> to <u>10/11</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Victor F. Hinc</u>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR F. HINC</u>				22d. ADDRESS <u>1102 E. Joyce Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/13/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase, Inc. 1328 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
11053
MARYLAND STATE DEPARTMENT
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Winters Lane Extended			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Virginia Middle Alverta Last Beverly				4. DATE OF DEATH Month October Day 23 , Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28, 1877	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Cornelius Gross				14. MOTHER'S MAIDEN NAME Anna Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Beatrice Kane				Address Winters Lane Extended			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Degenerative Heart Disease (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 60 to 10/23/60 , that (I) was last saw the deceased alive on 10/23/60 , and that death occurred 10:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE W.E. McGreth M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10/26/60							
22c. PHYSICIAN'S NAME (Type) W.E. McGreth M.D. 22d. ADDRESS 1303 Frederick Rd Catonsville Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/60		23c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery		23d. LOCATION (City, town, or county) (State) Catonsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Harris				25a. REC'D BY REGISTRAR DATE OCT 26 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Harris							

11053

11053

CENTRAL DE BEATH

California

California

California

October

January

February

March

April

May

June 25, 1911

July

August

September

October

November

December

January

February

March

April

May

June

July

August

September

October

11054

CERTIFICATE OF DEATH

Reg. Dis. No. 11030

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Son's 1860 Loch Shiel Rd. home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Cecelia</i> Middle <i>Borig</i> Last		4. DATE OF DEATH Month <i>10</i> Day <i>14</i> Year <i>19 60</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-26-1891</i>
9. AGE (In years last birthday) yrs. <i>69</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Mann</i>		14. MOTHER'S MAIDEN NAME <i>Mary Whittaker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William F. Borig</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca. of uterus (adenocarcinoma)</i> DUE TO (b) <i>174X</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19 58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>19 58</i> , 19 <i>60</i> , to <i>10/14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>10/14</i> , 19 <i>60</i> , and that death occurred at <i>3:15</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur S. Kraus</i> M.D.		ADDRESS (Street, city or town, state) <i>4531 Harford Road.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>10-17-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 18 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

11055

11031

1. PLACE OF DEATH o. COUNTY BALTIMORE CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS MD.		c. LENGTH OF STAY IN 1b 3 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PEARL Middle HADAWAY Last BORN		4. DATE OF DEATH Month OCT. Day 21 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 13, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) GEORGIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS GARLAND HADAWAY		14. MOTHER'S MAIDEN NAME CYNTHIA ALLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
INFORMANT SW WILLIAM BORN		Address PIKESVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis - Chronic DUE TO Decompensating Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO Arteriosclerosis (c) —			INTERVAL BETWEEN ONSET AND DEATH 5 yrs year year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from 1-1-36 to 10-22-60 , that I last saw the deceased alive on 10-21-60 , and that death occurred at 12:05 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Saffell		DATE SIGNED 10-22-60	
PHYSICIAN'S NAME (Type) James G. Saffell MD		ADDRESS (Street, city or town, state) Reisterstown MD Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/24/60	22c. NAME OF CEMETERY OR CREMATORY OCOONEE CEM.	22d. LOCATION (City, town, or county) (State) ATHENS GA.
23. FUNERAL DIRECTOR'S SIGNATURE James H. Saffell		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR DATE OCT 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11032

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balti.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bendix Radio Co., Joppa Rd.</i>		d. STREET ADDRESS <i>8358 Oakleigh Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ward</i> Middle <i>Joseph</i> Last <i>Bowers</i>		4. DATE OF DEATH Month <i>10</i> Day <i>7</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-2-1917</i>
9. AGE (In years last birthday) <i>43</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Model Shop</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Luther Bowers</i>		14. MOTHER'S M maiden NAME <i>Margaret Greiser</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>215013306</i>	
17. INFORMANT <i>Dorothy E. Bowers</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <i>331X</i> DUE TO (c) <i>storing the underlying cause lost.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>10-10-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Hartford Rd.</i>	
24a. REC'D BY REGISTRAR <i>10 10 60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

11035

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11035

NAME OF DECEASED JAMES EARL RAY		SEX MALE		AGE 35	
DATE OF DEATH 4-4-68		PLACE OF DEATH BALTIMORE, MARYLAND		HOSPITAL ST. JOSEPH'S HOSPITAL	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNATURE OF EXAMINER J. W. RAY	
LOCALITY BALTIMORE, MARYLAND		CITY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201		DATE OF EXAMINATION 4-4-68	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF CHAPLAIN	
SIGNATURE OF SOCIAL WORKER		SIGNATURE OF CLERK		SIGNATURE OF OTHER	

RECEIVED
APR 10 1968
BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11057

11033

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOT BROOK</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>MAY</u> Last <u>BRADY</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>15</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>	IF UNDER 24 HRS. Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>DAISEY-HOWARD CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES M^{rs} DONALD</u>		14. MOTHER'S MAIDEN NAME <u>NAOMI ESWORTHY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>John Brady - CARROLL CO. MD. (SON)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Uremia</u> (c) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>October 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October 15</u> , 19 <u>60</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. Williams</u> M.D. <u>11904 Reisterstown Rd. Reisterstown, MD</u>		DATE SIGNED <u>Oct 15, 1960</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY FAMILY</u>		22d. LOCATION (City, town, or county) (State) <u>HARRISONVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikeville S. Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>OCT 18 '60</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11058
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Roberts Ave.		d. STREET ADDRESS 2 Roberts Ave.	
3. NAME OF DECEASED (Type or print) First Walter Middle Brooks Last Brooks		4. DATE OF DEATH Month Oct. Day 29, Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1905
9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR Months 29, Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Neal		14. MOTHER'S MAIDEN NAME Jennie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Mary A. Matthew 2 Roberts Ave. Catonsville, Md.	
17. INFORMANT Mary A. Matthew 2 Roberts Ave. Catonsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-8-60 , 19____, to 10-29-60 , 19____, that I last saw the deceased alive on 10-29-60 , 19____, and that death occurred at 10.30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane Catonsville, 28. Md. DATE SIGNED 10/29/60			
ACTUAL SIGNATURE C.F. Maloney, M.D.		PHYSICIAN'S NAME (Type) C.F. Maloney, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/60	
22c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery		22d. LOCATION (City, town, or county) (State) Catonsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Halstead & March 918 Druid Hill Ave.		24a. REC'D BY REGISTRAR DATE OCT 31 '60	
24b. REGISTRAR'S SIGNATURE Charles L. Hume			

CERTIFICATE OF DEATH

11938

11938

NAME OF DECEASED: *John A. Smith*

REPORT MADE BY: *John A. Smith*

DATE OF DEATH: *Jan 1, 1938*

PLACE OF DEATH: *Home*

AGE: *65*

SEX: *Male*

RACE: *White*

DATE OF BIRTH: *Nov 1, 1872*

PLACE OF BIRTH: *St. Louis, Mo.*

EDUCATION: *High School*

OCCUPATION: *Teacher*

CAUSE OF DEATH: *Heart Disease*

MANNER OF DEATH: *Natural*

PLACE OF INTERMENT: *St. Mary's Cemetery*

DATE OF INTERMENT: *Jan 2, 1938*

SIGNATURE OF REPORTER: *John A. Smith*

DATE OF SIGNATURE: *Jan 1, 1938*

NAME OF PHYSICIAN: *Dr. J. H. Jones*

DATE OF EXAMINATION: *Jan 1, 1938*

NAME OF CORONER: *John A. Smith*

DATE OF EXAMINATION: *Jan 1, 1938*

NAME OF JURY: *John A. Smith*

DATE OF EXAMINATION: *Jan 1, 1938*

NAME OF JURY: *John A. Smith*

DATE OF EXAMINATION: *Jan 1, 1938*

NAME OF JURY: *John A. Smith*

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DATE OF EXAMINATION: *Jan 1, 1938*

NAME OF JURY: *John A. Smith*

DATE OF EXAMINATION: *Jan 1, 1938*

NAME OF JURY: *John A. Smith*

DATE OF EXAMINATION: *Jan 1, 1938*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11059

CERTIFICATE OF DEATH

Reg. Dist. No. 11035

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Touson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Touson</u> <u>SS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 Fairmount ave</u>		d. STREET ADDRESS <u>412 Fairmount ave</u>	
3. NAME OF DECEASED (Type or print) First <u>HIRAM</u> Middle <u>S.</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Families</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Brown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-32-0773</u>	
17. INFORMANT <u>Florence Brown</u>		Address <u>412 Fairmount ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate + bones</u> 1777X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>One year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-2</u> , 19 <u>59</u> , to <u>10-29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-28</u> , 19 <u>60</u> , and that death occurred at <u>2:50 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank A. Saunders</u> M.D.		ADDRESS (Street, city or town, state) <u>1029 n. Stricker St Baltimore 17 md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK A. SAUNDERS MD.</u>		DATE SIGNED <u>11-1-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	22d. LOCATION (City, town, or county) (State) <u>Touson Balto. co. md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chatman Jr.</u>		ADDRESS <u>1701 Mc Culloch St. Balto. md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

11650

CERTIFICATE OF DEATH

11650

[Faint, illegible text on a death certificate form, likely bleed-through from the reverse side. The form includes fields for Name, Age, Sex, Date of Birth, Date of Death, Cause of Death, and Place of Death.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11037**

11060

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE HALL MD				c. LENGTH OF STAY IN 1b 10 YEARS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHITE HALL MD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillian First C Middle Chenoweth Last			4. DATE OF DEATH Month OCT Day 27 Year 1960				
5. SEX FEMALE	6. COLOR OR RACE WHITE.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 9, 1883		9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months 27 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHAN COLE				14. MOTHER'S MAIDEN NAME ELIZA L. HOPKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT HOWARD CHENOWETH Address WHITE HALL MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage DUE TO (c) Generalized arteriosclerosis & hypertension						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1958 to 26 Oct. 1960 , that I last saw the deceased alive on 26 Oct. 1960 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Reginald B. Gemmill				ADDRESS (Street, city or town, state) Stewartstown, Pa.		DATE SIGNED 28 Oct. 1960	
PHYSICIAN'S (Type) Reginald B. Gemmill							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT 31, 1960		22c. NAME OF CEMETERY OR CREMATORY MORRISDALE MEM PARK		22d. LOCATION (City, town, or county) (State) BALTO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Isaac Funeral Home 7401 Belair Road #6 Md				24a. REC'D BY REGISTRAR NOV 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11038

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> <u>51</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5517 Link Ave.</u>				d. STREET ADDRESS <u>5517 Link Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Clark</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Clark</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Mullin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Gertrude Fritz</u> Address <u>5517 Link Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>422.1</u> DUE TO <u>Generalized Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/10/58</u> to <u>10/9</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>10/9</u> 19 <u>60</u> , and that death occurred <u>9:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph G. Laukaitis</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Joseph G. LAUKAITIS MD</u>				22d. ADDRESS <u>679 Washington Blvd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/12/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase, Inc. 1328 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11039

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 7</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3608 Croydon Rd.</u>				d. STREET ADDRESS <u>3608 Croydon Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>R.</u> Last <u>CLEAR</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 18, 1885</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C & P Tel. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>-- Clear</u>				14. MOTHER'S MAIDEN NAME <u>--</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. M. Clyde Murphy - 3608 Croydon Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) - Arteriosclerotic Heart -</u> DUE TO <u>Ischemic</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>(2) - Cancer of Prostate -</u> DUE TO <u>Prostate</u> (c) <u>(3) Paget Disease -</u>						INTERVAL BETWEEN ONSET AND DEATH. <u>5 yrs.</u> <u>1 yr.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 25</u> 19 <u>60</u> to <u>Oct. 19</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct. 18</u> 19 <u>60</u> , and that death occurred at <u>3:40</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl L. Chambers</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers -</u>				22d. ADDRESS <u>4108 Liberty Hts. Ave. Balto.-md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balto. Md.</u>				ADDRESS <u>Mid</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Conrad L. Thomas</u>			

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11041

1. PLACE OF DEATH a. COUNTY Balto.				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12				c. LENGTH OF STAY IN 1b 3				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS formerly of 5007 Ivanhoe Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET H. COARD				First Middle Last				4. DATE OF DEATH Oct. 12, 1960				Month Day Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1879		9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? ---			
13. FATHER'S NAME Carl Humberg				14. MOTHER'S MAIDEN NAME Maria -											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-12-0855B				17. INFORMANT Mrs. W. Kenneth Root - 37 Burke Ave., Towson 4				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4-22-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arterio sclerotic C.V. Disease DUE TO (c) ---								INTERVAL BETWEEN ONSET AND DEATH 9/19/60 5 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 10, 1960 , to Oct. 12, 1960 , that (I) (we) last saw the deceased alive on Oct. 11, 1960 , and that death occurred 5:50 A.M. , from the causes and on the date stated above.															
22a. SIGNATURE Carl F. Benson M.D.				22b. DATE SIGNED Oct 14 '60				22c. PHYSICIAN'S NAME (Type) Carl F. Benson M.D.				22d. ADDRESS 5111 York Rd. Balto. 12 Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 15, 1960				23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park				23d. LOCATION (City, town, or county) (State) Balto., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lieber				ADDRESS 4001 York Rd. Balto. 17 Md.				25a. REC'D BY REGISTRAR DATE OCT 14 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11061

CERTIFICATE OF DEATH

11062

7

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Balto Co</u> b. COUNTY <u>Balto Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landsdown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landsdown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3107 Hammond Ferry Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Otto Scott Colder</u> First Middle Last		4. DATE OF DEATH <u>Oct 17 1960</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27-1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Colder</u>		14. MOTHER'S MAIDEN NAME <u>Ann Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>217-07-3974</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 1444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Metastasis</u> DUE TO (c) <u>Carcinoma of mouth</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1959</u> , 19, to <u>Oct 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 16</u> , 19 <u>60</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo M. Kieffer</u> M.D.		ADDRESS (Street, city or town, state) <u>1010 Leaden</u>	
PHYSICIAN'S NAME (Type) <u>GEO. S. M. KIEFFER M.D.</u>		DATE SIGNED <u>Oct 18-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 20-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. City</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo J. Schuchman</u>		24a. REC'D BY REGISTRAR <u>2101 Frederick Ave</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>
DATE <u>Oct 21 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11063

11043

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS 526 Castle Drive #12	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last CONNER		4. DATE OF DEATH Month Oct. Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Electric Appliances	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Conner		14. MOTHER'S MAIDEN NAME Mary Kuckle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Grace Tavenner-526 Castle Drive #12		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate course (a), stating the underlying cause lost: (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 2, 1960 to Oct. 29, 1960 , that (I) (we) last saw the deceased alive on Oct. 29, 1960 , and that death occurred at 5:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED 10/31/60	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST		22d. ADDRESS 6805 York Rd. Baltimore 12 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor		25a. REC'D BY REGISTRAR NOV 2 '60	
ADDRESS Baltimore - 17, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11063

CENTRAL AIR OF INDIANA

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TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
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[The bottom half of the document contains several large, faint, handwritten-style markings or signatures that are difficult to decipher. Some appear to be names or initials.]

CERTIFICATE OF DEATH

Reg. Dist. No. 11044

11064

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Pikesville 8, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>#3 Reservoir Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Petrina</u> Last <u>Corkran</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16, 1909</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mt. Wilson</u>	
11. BIRTHPLACE (State or foreign country) <u>Yatesborough, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Enuzio Panebianco</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Riso</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-38-0170</u>	
17. INFORMANT <u>Mr. Milton W. Corkran, #3 Reservoir Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid with liver metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u> </u> (c) <u> </u> 153.3 DUE TO <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>29rs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>14 Oct</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>14 Oct</u> , 19 <u>60</u> , and that death occurred at <u>10:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gaul Royse</u>		ADDRESS (Street, city or town, state) <u>1403 Foley Lane Pikesville 8 Md.</u>	
PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE MD</u>		DATE SIGNED <u>15 Oct 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 17, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11011

DECLARATION OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11065

CERTIFICATE OF DEATH

Reg. Dist. No. 11045

M

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4 mo. 15 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>				d. STREET ADDRESS <u>1537 S. Rolling Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth J. Cory</u>				4. DATE OF DEATH Month Day Year <u>Oct. 21st., 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 13, 1879</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wales</u>	
13. FATHER'S NAME <u>George Rees</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>174-01-3860D</u>			
17. INFORMANT <u>Miss Constance Cory</u>				Address <u>Relay 27, Md.</u> <u>1537 S. Rolling Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. S. C. V. D. & terminal</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hemipar</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sept 15, 1960, to 10/21, 1960</u>	
20f. (City or town) <u>Relay</u>				20g. (County) <u>Relay</u>			
20h. (State) <u>Md.</u>				20i. (Country) <u>U. S. A.</u>			
21. I certify that I attended the deceased from <u>Sept 15, 1960</u> , to <u>10/21, 1960</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>60</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1305 FRANCIS AVE ARROYO US-27, MD</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>John B. Healy</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/24/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Millersville, Md.</u>				22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>				ADDRESS <u>Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>				24c. (City, town, or county) <u>Relay</u>			
24d. (County) <u>Relay</u>				24e. (State) <u>Md.</u>			

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11085

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11066

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11046

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 15 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 Nunnery Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MASSIMO COZZI		4. DATE OF DEATH Oct. 20, 1960	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor		10b. KIND OF BUSINESS OR INDUSTRY Altone Tailors	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cozzi		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-07-5739	
17. INFORMANT Mrs Dora Cozzi, 25 Nunnery Lane #28 Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma right gingiva & jaw DUE TO left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1960 DUE TO (c) 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic cardio vascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1955 to present , 19 60 , that (I) (we) lost the deceased alive on Oct. 18 1960 , and that death occurred at 10 A M, from the causes and on the date stated above.			
22a. SIGNATURE Arthur G. Siwinski M.D.		22b. DATE SIGNED 10-21-60	
22c. PHYSICIAN'S NAME (Type) Arthur G. Siwinski		22d. ADDRESS 15 E. Biddle Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 24/60	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave #29, Md.		25a. RECEIVED BY REGISTRAR Oct 25 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	

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SEE US AT

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Spontaneous cell carcinoma arising in jaw

12752

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02-91-100

69-15-01

At 5:00 p.m. on 12/12/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11067

CERTIFICATE OF DEATH

Reg. Dist. No.

11047

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greenspring Ave. Lutherville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle Jeanette Last Cronhardt		4. DATE OF DEATH Month 10 Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1896
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner		10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George S. Forwood		14. MOTHER'S MAIDEN NAME Helen Waterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-22-6409	
17. INFORMANT Myron A. Cronhardt		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Colon with Metastasis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Dec. 1953 to Oct 26th, 1960 , that I last saw the deceased alive on Oct 25th, 1960 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. Miller M.D.		ADDRESS (Street, city or town, state) 1331 Reisterstown Rd, Pikesville, Md.	
PHYSICIAN'S NAME (Type) James A. Miller M.D.		DATE SIGNED 10/27/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-60	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md.		24a. REC'D BY REGISTRAR OCT 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

14007

CENTRAL OF GEORGIA

Baltimore

Baltimore

Indianapolis

Indianapolis

Indianapolis

Georgetown Ave. Indianapolis

Georgetown Ave. Indianapolis

Evans

Georgetown Ave. Indianapolis

Female White

1896-1897

Examiner

Clinton W.C.

Clinton W.C.

George H. Thomas

Helen Watson

NO

214-22-6409 Merton A. Cronhardt Above

Brooks General Service Towns # 15.
10-29-60 Draft Bridge
Towns # 15, Maryland

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11068

11048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 45 Minutes				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (31)							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital								d. STREET ADDRESS 13 South Ann Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES		First		Middle ---		Last CZYZIA		4. DATE OF DEATH October 13, 1960		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH September 22, 1907		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10b. KIND OF BUSINESS OR INDUSTRY Tailoring				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Samuel Czyzia								14. MOTHER'S MAIDEN NAME Josephine Majka							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 216-09-8933				17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE BILATERAL ADRENAL HEMORRHAGE (WATERHOUSE-FRIDERICHSEN SYNDROME) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490X DUE TO LOBAR PNEUMONIA, BILATERAL, PNEUMOCOCCAL (c) DUE TO												INTERVAL BETWEEN ONSET AND DEATH 1 DAY Plus 4 DAYS Plus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE- DURATION UNKNOWN															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6:00 PM 10/13/60 to 6:45 PM 10/18/60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/13/60 19____, and that death occurred at 6:45 P. M. from the causes and on the date stated above.															
22a. SIGNATURE Frederick S. Donaldson								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 10/14/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.								22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-19-60				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town, or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Dippel Brothers, Inc. 1800 E. Lombard St. (24)								25a. REC'D BY REGISTRAR OCT 17 '60				25b. REGISTRAR'S SIGNATURE Charles S. Howard			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11069

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11049

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b Fruitland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS Poplar St 22X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROLAND Middle DASHIELL Last DASHIELL				4. DATE OF DEATH Month 10 Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-1918	
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Dashiehl				14. MOTHER'S MAIDEN NAME Georgia Farnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 154-01-3363		17. INFORMANT Hosp. Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 002X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 5 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10-7-1960 to 10-11-1960 , that (I) (we) last saw the deceased alive on 10-11-1960 and that death occurred at 7:28 PM from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent				22d. ADDRESS Mt. Wilson St. Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-16-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town, or county) (State) Fruitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Solley, Salisbury, Md				25a. REC'D BY REGISTRAR OCT 20 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11070
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11050

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 MAPLE AVE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 108 MAPLE AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) A. ELLA DAVIS First Middle Last 4. DATE OF DEATH OCT. 9 1960 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11/2/71 9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WM. MERSON 14. MOTHER'S MAIDEN NAME SCOTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT EMANUEL DAVIS Address (50N)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basil Cell Carcinoma of Jaw. 191.3 DUE TO Broncho Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 1956 to Oct 9 1960 that (I) (we) last saw the deceased alive on Oct 8 1960 and that death occurred at 530A from the causes and on the date stated above. 22a. SIGNATURE Wm. Lee Fort M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Wetherbee Fort 22d. ADDRESS 6 outton ave, Catonsville 28 md 22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 10/11/60 23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S 23d. LOCATION (City, town, or county) (State) HOWARD CO. MD.		24. FUNERAL DIRECTOR'S SIGNATURE Don 28 ADDRESS 25a. REC'D BY REGISTRAR DATE OCT 13 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11071

11051

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 c. LENGTH OF STAY IN 1b 28 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House in the Pines 16 Rusting Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore 29 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29 d. STREET ADDRESS 810 North Chapel Gate Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle C. Last Davis		4. DATE OF DEATH Month October Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1895
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army (ret'd)	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW II (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-07-0521		17. INFORMANT Wm. E. Schoeberlein, 924 Masfield Rd. ZONE 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung (Bronchogenic Carc.) DUE TO (b) 3 1/2 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 162.1 DUE TO (b) 3 1/2 mos DUE TO (c) 162.1		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/30, 1960 , to 10/5, 1960 , that I last saw the deceased alive on 10/5, 1960 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Max J. Miller		ADDRESS (Street, city or town, state) 1047 Ingleside Ave, Baltimore	
PHYSICIAN'S NAME (Type) Max J. Miller, M.D.		DATE 280/7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-10-60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR OCT 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

11051

WARRANT FOR THE ARREST OF

CERTIFICATE OF DEATH

11051

Register

For the

of the

County of

State of

City of

and

County of

State of

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11072
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11052

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1302 Iverness Ave Baltimore, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1821 Loch Shiel Rd.		d. STREET ADDRESS 1302 Iverness Ave. 3404	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Katharina Doll		4. DATE OF DEATH 10/25/60	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Henriette Harman, 1821 Loch Shiel Rd. #4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Sarcinomatosis DUE TO possib originating from Rt. ovary Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) 2 month DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March, 1960 to 10.25. 1960 , that (I) (we) last saw the deceased alive on 10.24. 1960 , and that death occurred at 7:45 M. from the causes and on the date stated above.			
22a. SIGNATURE Justina Kudirka		22b. DATE SIGNED 10.26.60	
22c. PHYSICIAN'S NAME (Type) Justina KUDIRKA		22d. ADDRESS 2151 Wilkens Ave, Baltimore Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/28/60	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town, or county) (State) A.A. County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR OCT 28 '60	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11073 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11053

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MD b. COUNTY Balto- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE Pikesville											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrison				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE Pikesville											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Foxleigh Nursing Home				d. STREET ADDRESS 3400 Winterset Court											
3. NAME OF DECEASED (Type or print) ESTHER HINDA DOPKIN				4. DATE OF DEATH Month Oct Day 26 Year 1960											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 4, 1893									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		9. AGE (In years last birthday) 67 yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	12. CITIZEN OF WHAT COUNTRY? USA	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
13. FATHER'S NAME Isadore Goldman				14. MOTHER'S MAIDEN NAME Sarah M. ?											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None				17. INFORMANT Address Mr. Wilford Dopkin Same											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Heart disease DUE TO (b) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Fracture left femur--- Malnutrition due to esophageal diverticulum															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. No		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home aug 1959													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3 AM p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore, Md									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE D.D. Caples				CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) D.D. Caples				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
				DATE SIGNED 10/26/60											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew		22d. LOCATION (City, town, or country) (State) Baltimore, Md.									
23. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reisterstown Rd.				24a. REC'D BY REGISTRAR OCT 31 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

MEDICAL CERTIFICATION

FOR MAIL
POST OFFICE

11073

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11073

11073 MEDICAL EXAMINER - CERTIFICATE OF DEATH

AMERICAN PHYSICIAN

3450 WINTER ST. ST. LOUIS, MO.

JOHN H. HARRIS, M.D.

August 11, 1935

USA

Robert

Home

Indefinitely

Robert M. Harris

Indefinitely

Same

Mr. William Robert

Home

Investigation by C. E. Harris, M.D.

The same left Robert - maintained for the 10th anniversary of death

Tell as home in 1935

Baltimore, MD

Home

11

X

10/26/60

2

D. B. Hughes

Baltimore, MD

Baltimore, MD

10/26/60

SO. J. WILSON & SONS LTD. 4000 Richardson Rd. BALTIMORE, MD. 10/26/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11074

CERTIFICATE OF DEATH

11054
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ROSEDALE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1229 SIXTY-THIRD ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BEATRICE ELEANOR DWYER				4. DATE OF DEATH Month Day Year OCT. 21 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 17 1914	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS				10b. KIND OF BUSINESS OR INDUSTRY G.A. RESTAURANT		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ROBERT L. CROUT				14. MOTHER'S MAIDEN NAME LAURA ROBINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 218-05-2994			
17. INFORMANT Address JOSEPH J. DWYER 1229 63rd ST.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - Bronchopneumic Carcinoma DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 162-21 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mo.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 21, 1960 , to Oct. 21, 1960 , that I last saw the deceased alive on Oct. 21, 1960 , and that death occurred at 8:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen Toms, M.D.				ADDRESS (Street, city or town, state) 4810 Bowleys Lane			
DATE SIGNED 10/22/60							
PHYSICIAN'S NAME (Type) STEPHEN TOMS, MD.				BALTIMORE 6, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF OCT. 25, 1960			
22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH				22d. LOCATION (City, town, or county) (State) BALTO. CO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Geo. W. Hoffmann				ADDRESS 3218 HUDSON ST.			
24a. REC'D BY REGISTRAR OCT 24 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11074

CERTIFICATE OF DEATH

11074

BALTO

M.D.

WATIMORE

DATE

DATE

IN SIXTY-THIRD ST. WARD SIXTY-THIRD ST. BALTO

RECEIVED FROM THE BALTO

WHITE WHITE

WATIMORE

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11075

11055

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 1649 Jackson ST			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EARL Middle EDWARD Last EIDMAN				4. DATE OF DEATH Month 10 Day 26 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-05	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN E. EIDMAN				14. MOTHER'S MAIDEN NAME EMMA SCHWEIM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 217-07-6987		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESOPHAGEAL VARICES DUE TO (c) PULMONARY TUBERCULOSIS, DIABETES							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —				20f. (City or town) (County) (State) —			
21. I certify that (I) (this hospital) attended the deceased from 5-6 1960 to 10-26 1960 that (I) (we) last saw the deceased alive on 10-26 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 10/28/60			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/60		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. Cully Funeral Homes 130 E. Fort Ave. jhh				25a. REC'D BY REGISTRAR DATE Oct 28 60			
25b. REGISTRAR'S SIGNATURE Carlton S. House							

MEDICAL CERTIFICATION

11052

CENTRAL JAIL OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11056

11078

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> <i>55</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1105 Register Ave.</i>		d. STREET ADDRESS <i>1105 Register Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>H.</i> Last <i>Eliff</i>		4. DATE OF DEATH Month <i>10</i> Day <i>10</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-9-1886</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR: Months <i>74</i> Days <i>10</i> Hours <i>19</i> Min. <i>60</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Eliff</i>		14. MOTHER'S MAIDEN NAME <i>Eluy Norris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>212321468</i>	
17. INFORMANT <i>Frances Eliff</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Lung (Left)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>163X</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 15, 59</i> to <i>Oct. 10, 19 60</i> , that I last saw the deceased alive on <i>Oct. 10, 19 60</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Laurence C. Post</i>		ADDRESS (Street, city or town, state) <i>6805 York Rd. Baltimore 12 Md</i>	
PHYSICIAN'S NAME (Type) <i>LAURENCE C. POST</i>		DATE SIGNED <i>10/11/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>10-13-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR <i>DATE OCT 13 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11073

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1900		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 Main St.		Carpenter		Heart Disease		Natural		1945		New York	
Physician		Funeral Director		Burial Place		Date of Burial		Place of Burial		Cemetery	
Dr. J. J. Jones		J. J. Jones		St. John's Church		1945		St. John's Church		St. John's Cemetery	
Signature of Physician		Signature of Funeral Director		Signature of Registrar		Signature of Deceased		Signature of Next of Kin		Signature of Witness	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

11073

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11077

11057

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5200 CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 SEMINOLE AVE				d. STREET ADDRESS 1506 SEMINOLE AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA MAY ENNIS				4. DATE OF DEATH Month Day Year October 30 1960			
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 18, 1885		9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hastings				14. MOTHER'S MAIDEN NAME Nancy E. Grauehor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address Mrs. Doris McCurdy 506 SEMINOLE AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 450.0 DUE TO Arteriosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Generalized DUE TO (c) Arteriosclerosis, Generalized INTERVAL BETWEEN ONSET AND DEATH 12 hr. years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to 10/30 19 60 , that (I) (we) last saw the deceased alive on 10/30 19 60 , and that death occurred about 10:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE E. P. Williamson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/30/60	
22c. PHYSICIAN'S NAME (Type) E. P. WILLIAMSON				22d. ADDRESS 5550 BALTO. NAT'L PIKE BALTIMORE 28 Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 2, 1960		23c. NAME OF CEMETERY OR CREMATORY WOOD MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) SALISBURY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

11057

CERTIFICATE OF DEATH

11057

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11078
CERTIFICATE OF DEATH

11058

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 443 Whitfield Road		d. STREET ADDRESS 443 Whitfield Road 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle E. T. Last EWELL		4. DATE OF DEATH Month Oct. Day 30 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1890
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	12. CITIZEN OF WHAT COUNTRY? Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Oscar B. B. Ewell		14. MOTHER'S MAIDEN NAME Mary -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Minnie Ewell-443 Whitfield Road #28		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of lung 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Carcinoma of sigmoid colon DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 8/1/58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 0		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 24, 1955 to Oct. 30, 1960 , that (I) (we) last saw the deceased alive on Oct. 29, 1960 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Harry L. Knipp		22b. DATE SIGNED 10/31/60	
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M. D.		22d. ADDRESS 4116 Edmondson Avenue #29	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

11058

CERTIFICATE OF DEATH

11058

Bellevue

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11079

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11059

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1110 Chesaco Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle F. Last Ey				4. DATE OF DEATH Month October Day 29 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1913		9. AGE (In years lost birthday) 47 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Martin Aircraft		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Ey				14. MOTHER'S MAIDEN NAME Louise Pocock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-5852		17. INFORMANT Mr. Clarence Ey Jr. Address 1110 Chesaco Ave. 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis of heart & vessels DUE TO (c) 0532							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 22 June 1958 to 14 Aug 1958 that (I) (we) last saw the deceased alive on 12 Oct 1960 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Joseph M. White M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 8019 Phila Rd Balto, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Zion Evan. Lutheran		23d. LOCATION (City, town, or county) (State) Golden Ring Rd. Bal to. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lashley Funeral Home				25a. REC'D BY REGISTRAR 7401 Belair Rd.		25b. REGISTRAR'S SIGNATURE Charles S. Kneass	

11070

CERTIFICATE OF DEATH

11070

1

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11080

11060

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Granite, Md.</u>		c. LENGTH OF STAY IN 1b <u>8 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARG. ELIZ. FERGUSON</u>		4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing</u>	
11. BIRTHPLACE (State or foreign country) <u>Granite</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Louis Klein</u>		14. MOTHER'S MAIDEN NAME <u>Julia Frances Nash</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-01-8807</u>	
17. INFORMANT <u>Marg. Klein Price - 21 Burgin Ln</u>		Address <u>21 Burgin Ln</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.-V. Disease</u> <u>260 X</u> DUE TO (b) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cold & Chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>12 yrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-4-60</u> ACTUAL SIGNATURE <u>D.D. Caples</u> M.D. EXAMINER'S NAME (Type) <u>D.D. CAPLES, M.D.</u> Address (Street, city, town, or county) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Granite Presbyterian Cem.</u>		22d. LOCATION (City, town, or country) _____ (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR <u>Elisworth Armacost-4600</u>		24. REC'D BY REGISTRAR <u>OCT 4 '60</u>	
24a. ADDRESS <u>Liberty Hghts. Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrash</u>	

11080

11080

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS

(M)

(1)

DECEASED
NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
CITY OF RESIDENCE
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF MEDICAL EXAMINER
DATE OF EXAMINATION

VR A15 (4)
15M 9/59

may be released by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11081

Items 8, 9 Film 6273 10-20-60 et

11061

1. PLACE OF DEATH o. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines Nursing Home		d. STREET ADDRESS 1110 S. Carey st.	
3. NAME OF DECEASED (Type or print) JAMES W. FINECEY		4. DATE OF DEATH Month October Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 22nd Feb. 1870
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (Unknown) Finecey		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Ethel Schmidt #9 Ferndale Ave., Glen Burnie, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO 171 (c) General arteriosclerosis 187		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-29-1960 to 10-5-1960 that (I) (we) last saw the deceased alive on 10-5-1960 and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE SIGNED 6-20-60	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		22d. ADDRESS 6209 Frederick Ave., Balt. 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8th Oct. 1960	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Richard V. Sargis		25a. REC'D BY REGISTRAR DATE OCT 10 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11082
11062
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b 1090 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2102 Lake Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY First FISCHER Middle Fischer Last 4. DATE OF DEATH Month Oct. Day 5, Year 19 60				5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 9, 1883 9. AGE (In years lost birthday) 77 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Fischer				14. MOTHER'S MAIDEN NAME Bertha ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elizabeth F. Sheppard - 2102 Lake Ave. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Throat 148A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 18 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 23rd 1960 to Oct. 5th 1960 , that (I) (we) last saw the deceased alive on Sept. 29th 1960 , and that death occurred on Oct. 5th 1960 at 12:30 A.M., from the causes and on the date stated above.							
22a. SIGNATURE James A. Miller M.D.		22b. DATE SIGNED 10/6/60		22c. PHYSICIAN'S NAME (Type) James A. Miller M.D.		22d. ADDRESS 1331 Reisterstown Rd. Pikesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/60		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION (City, town, or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Sons - Balto. Md.				25a. RECEIVED BY REGISTRAR DATE Oct 7 1960		25b. REGISTRAR'S SIGNATURE William J. Vickner	

11085

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 may be retained for your files, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11063									
1. PLACE OF DEATH a. COUNTY Baltimore Sparrows Point b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethlehem Steel Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 2418 E. Fayette St. Zone #24 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James F. Fitzpatrick					4. DATE OF DEATH Month October Day 14 Year 19 60				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-19-1902		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William J. Fitzpatrick					14. MOTHER'S MAIDEN NAME Anna M. McPeake				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --- 213-05-7213		17. INFORMANT Anna M. Fitzpatrick			Address Same.		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) DUE TO Hyperuricemia - C-v-D cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None								INTERVAL BETWEEN ONSET AND DEATH —	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) M.B. Davis M.D. DATE SIGNED 10/14/60.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-60.		22c. NAME OF CEMETERY OR CREMATORY Sacred Haert Cemetery		22d. LOCATION (City, town, or country) (State) 7401 German Hill Rd., Md.			
23. FUNERAL DIRECTOR Charles S. Zeiler		ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		24a. REC'D BY REGISTRAR OCT 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11084

Item 9 Film 67-10-24-60 et

11064

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1512 Fairmount</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER FINCH FLAYHART</u>				4. DATE OF DEATH Month Day Year <u>October 13 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 24 1888</u>	
9. AGE (In years lost birthday) <u>72 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>medicine</u>		11. BIRTHPLACE (State or foreign country) <u>Towson Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry W. Flayhart</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Ruby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Navy - WW2</u>		17. INFORMANT <u>Mrs Elva W. Flayhart</u>		Address <u>503 Virginia Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1952</u> to <u>October 60</u> , that (I) (we) last saw the deceased alive on <u>Oct 11</u> 19 <u>60</u> , and that death occurred at <u>412a</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Lester A. Wall Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/13/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LESTER A. WALL JR</u>				22d. ADDRESS <u>1039 St Paul St, Baltimore 2</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>15 Oct. 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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11084

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11085

11065

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 30 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (13)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3301 Ramona Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle MATTHEW Last FRANK				4. DATE OF DEATH Month October Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 14, 1911	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min.		IF UNDER 24 HRS. Months 49 Days 49 Hours 49 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John P. Frank				14. MOTHER'S MAIDEN NAME Catherine Kleiderlein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 213-03-6845		17. INFORMANT VAH, Baltimore 18, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163X ANAPLASTIC CARCINOMA OF RIGHT UPPER LUNG AND 163X HYPOPHARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept. 19 19 60 to Oct. 19 19 60 , that (I) (we) last saw the deceased alive on Oct. 19 19 60 , and that death occurred at 10:30P M, from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/20/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/24/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat	
23d. LOCATION (City, town or county) (State) Balto Md							
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kline				ADDRESS 305744		25a. REC'D BY REGISTRAR DATE OCT 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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11086
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11066

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1048 Lakemont Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK EDW. FRANKLIN</u>		4. DATE OF DEATH <u>Oct. 23 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1911</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>guard Westinghouse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Franklin</u>		14. MOTHER'S MAIDEN NAME <u>Norah Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>Carolyn F. Franklin</u>	
17. INFORMANT <u>Carolyn F. Franklin</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary insufficiency</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1958</u> to <u>23 Oct 1960</u> that (I) (we) last saw the deceased alive on <u>25 Oct 1960</u> and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James E. Rowe</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe, M.D.</u>		22d. ADDRESS <u>1011 Frederick Ave. 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/26/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>MacNabb + Son</u>		25a. REC'D BY REGISTRAR <u>28</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		DATE <u>OCT 26 '60</u>	

may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11087

11067

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>103 HEIGHT HILL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonessville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Md</u>	
c. LENGTH OF STAY IN TB <u>off. B.M.</u>		d. STREET ADDRESS <u>1740 Homestead St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Conv. Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wm.</u> Middle <u>Geary</u> Last <u></u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/81</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Geary</u>		14. MOTHER'S MAIDEN NAME <u>Vain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Caton Ridge Records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>arterio sclerosis gen. coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Ar.</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 weeks</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> 19 <u>60</u> and that death occurred at <u>3:35</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		22d. ADDRESS <u>4605 EDMONDSON AVE #27</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10/5/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Stolt + Son & Co</u>		ADDRESS <u>28</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>OCT 6 '60</u>			

11081

CERTIFICATE OF DEATH

11081

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be a form with various fields and possibly a signature.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11088

11068

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3901 Dorchester Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ✓ First RAY Middle T. Last GEORGE				4. DATE OF DEATH Month OCTOBER Day 7 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 10/12/99		9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Junior, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William George				14. MOTHER'S MAIDEN NAME Julia Corley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 236-14-5429		17. INFORMANT Address Clin.Rec.VAH,Balto.Md. Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH WITH METASTASIS TO REGIONAL LYMPH NODES AND LIVER Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) MASSIVE HEMORRHAGE INTO THE G.I. TRACT DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN HOURS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xx (this hospital) attended the deceased from Oct. 6 19 60 to October 7 19 60 , that xx (we) lost saw the deceased alive on October 7 19 60 , and that death occurred at 3P.M. from the causes and on the date stated above.							
22a. SIGNATURE Arthur T. Faulk				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/8/60	
22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.				22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-11-60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR DATE OCT 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11088

CENTRAL OFFICE

11088

7



1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11089
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11069

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TOWSON CONVALESCENT HOME</u>		d. STREET ADDRESS <u>422 YORK ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE ESTELLA GERMAN</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER 24 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 23, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
13. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>CHARLES BOSLEY</u>		16. MOTHER'S MAIDEN NAME <u>MARY E. FREELAND</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>NONE</u>	
19. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Left</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1960</u> to <u>Oct. 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 24</u> 19 <u>60</u> , and that death occurred at <u>5:30 p.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Laurence C. Post</u>		22b. DATE SIGNED <u>10/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		22d. ADDRESS <u>6805 York Rd, Baltimore 12 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 27, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>TOWSON, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 28 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

11000

CERTIFICATE OF DEATH

11082

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11070

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 8 1/2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 2103-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME			d. STREET ADDRESS 269 S. POTOMAC ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle W Last GILL			4. DATE OF DEATH Month OCT Day 11 Year 1960		
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-1872	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCOMOTIVE ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME JOHN H GILL		
14. MOTHER'S MAIDEN NAME MARTHA MCCOMAS			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c) Syn.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4-18 19 60 to 10-11 19 60 that (I) (we) last saw the deceased alive on 10-11 19 60 , and that death occurred at 3P.M. from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/11/60.	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-14-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town, or county) (State) Hagerstown, Md		24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street			
25a. REC'D BY REGISTRAR OCT 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11091

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11071

1. PLACE OF DEATH a. COUNTY Balto 7 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 7				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3523 Sussex Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles H. Gogel Jr.				4. DATE OF DEATH 10 11 1960			
5. SEX m		6. COLOR OR RACE w		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-40	
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		11. BIRTHPLACE (State or foreign country) Balto; Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Gogel Sr.				14. MOTHER'S MAIDEN NAME Frances E. Fitzpatrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-09-8076		17. INFORMANT Mrs. Teresa R. Gogel Address 3523 Sussex Rd Balto 7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma, metastatic 180X DUE TO (b) 3 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-17 19 59 , to 10-11 19 60 , that (I) (we) last saw the deceased alive on 05-8-1960 , and that death occurred at 11 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Wm Carl Eberling M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Wm. Carl Eberling M. D.				22d. ADDRESS 401 Medical Arts Bldg.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-15-60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS 8728 Liberty Rd Randallstown, Md.		25a. REC'D BY REGISTRAR OCT 18 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Means	

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NOTED: This case

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

11092

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11072

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		c. LENGTH OF STAY IN 1b <u>19 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>012 ROSEWOOD STATE TRAINING SCHOOL</u>		d. STREET ADDRESS <u>1617 SUNSHINE ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>KENNETH</u> Middle <u>LYNN</u> Last <u>GREINER</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 27, 59</u>
9. AGE (In years lost birthday) yrs. <u>11</u> Months <u>11</u> Days <u>11</u> Hours <u></u> Min. <u></u>		10. IF UNDER 1 YEAR <u>11</u> IF UNDER 24 HRS. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES EMIT GREINER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE VIRGINIA FORHOFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ROSEWOOD RECORDS</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> 752X DUE TO <u>SEVERE NON-COMMUNICATED HYDROCEPHALY</u> Birth Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/7/1960</u> to <u>10/8/1960</u> , that (I) (we) last saw the deceased alive on <u>10/8/1960</u> , and that death occurred at <u>6:30</u> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry B. Butler MD</u>		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry B. Butler MD</u>		22d. ADDRESS <u>Owings Mills, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Lickner + Son Balto Md</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

69

1
the funeral director,
ana 2 should be filed with

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VR A1S (4)
15M 9/59

11093

11073

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sparrows Point			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 718 F Street				d. STREET ADDRESS 1 718 F Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles E. Grupp, Sr.		First Middle Last		4. DATE OF DEATH October 23, 1960		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottling Dept.		10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph F. Grupp				14. MOTHER'S MAIDEN NAME Elizabeth Keifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Lillian Christian 718 F. Street-19			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1955-02-23		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1955 to Oct 23, 1960 , that (I) (we) last saw the deceased alive on Oct 10, 1960 , and that death occurred at 10:25 M., from the causes and on the date stated above.							
22a. SIGNATURE R G Windsor				22b. DATE SIGNED 10-25-60		22c. PHYSICIAN'S NAME (Type) R G WINDSOR	
22d. ADDRESS 520 D St. BALT 19, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27, 1960		23c. NAME OF CEMETERY OR CREMATORY Moteland Memorial Park		23d. LOCATION (City, town, or county) (State) Parkville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.				25a. REC'D BY REGISTRAR DATE OCT 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kras	

11033

CERTIFICATE OF DEATH

11033

1

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11094

11074

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.			c. LENGTH OF STAY IN 1b 14 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (14)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 7909 Elmhurst Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUSSELL Middle R. Last HAGEN				4. DATE OF DEATH Month October Day 14 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1893	
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 67		11. IF UNDER 24 HRS. Days 67 Hours 67 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molder				10b. KIND OF BUSINESS OR INDUSTRY Construction Work		11. BIRTHPLACE (State or foreign country) Richmond, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Cornelius Hagen				14. MOTHER'S MAIDEN NAME Ella Grimes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Clinical Records, VAH, Balto 18, Md FT. HOWARD DIV.			
17. INFORMANT Clinical Records, VAH, Balto 18, Md FT. HOWARD DIV.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, MASSIVE 155.0 DUE TO RUPTURE OF ESOPHAGEAL VARICES HEPATOMA MULTICENTRIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXXX PORTAL CIRRHOSIS OF LIVER METASTATIC CARCINOMA OF LIVER AND PANCREAS							INTERVAL BETWEEN ONSET AND DEATH SECONDS UNKNOWN UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 30 1960 , to October 14, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 14 1960 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick S. Donaldson</i> M.D.				22b. DATE 10/14/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road, Balto 14, Md.				25a. REC'D BY REGISTRAR DATE OCT 18 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	

11074

CERTIFICATE OF DEATH

11074

M

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11075

Reg. Dist. No.

11095

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u>		c. LENGTH OF STAY IN 1b <u>6 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X TIMONIUM</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>36 BELFAST RD.</u>				d. STREET ADDRESS <u>1 36 BELFAST RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>BAYARD</u> Middle <u>HALE</u> Last				4. DATE OF DEATH <u>OCT.</u> Month <u>17</u> Day <u>1960</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-80</u>		9. AGE (In years last birthday) <u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ELIJAH HALE</u>				14. MOTHER'S MAIDEN NAME <u>WHEELER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-20-5122</u>		17. INFORMANT Address <u>MRS. ALICE HALE 36 BELFAST RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> DUE TO <u>HANGING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 974X (b) <u>HANGING</u> (c) <u>HANGING</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PINE GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>RAYVILLE - BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM Cook-Towson-Towson 4-MD</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR STATE
HEALTH DEPT

M

11075

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11075

DATE OF DEATH
1907

TIME OF DEATH
11:00 AM

PLACE OF DEATH
HOME

AGE
65

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
FARMER

PREVIOUS ILLNESS
NONE

CAUSE OF DEATH
HEART DISEASE

MANNER OF DEATH
NATURAL

SIGNATURE OF EXAMINER
J. H. SMITH

DATE OF EXAMINATION
1907

PLACE OF EXAMINATION
HOME

TIME OF EXAMINATION
11:00 AM

PLACE OF EXAMINATION
HOME

TIME OF EXAMINATION
11:00 AM

PLACE OF EXAMINATION
HOME

TIME OF EXAMINATION
11:00 AM

PLACE OF EXAMINATION
HOME

TIME OF EXAMINATION
11:00 AM

11096

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28

1
50

1

2

1

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

2

1

BP

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11076

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 44 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last HALLAMEYER				4. DATE OF DEATH Month October Day 26 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1902	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter				10b. KIND OF BUSINESS OR INDUSTRY Gas and Electric		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Frank Hallameyer				14. MOTHER'S MAIDEN NAME Anna Ruppert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. WW II			
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland				18. ADDRESS FORT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT LUNG 162.1 162.1 WITH METASTASES TO THE LUNGS, LEFT ADRENAL AND BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. EMPHYSEMA (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from September 12, 1960 , to October 26, 1960 , that (we) last saw the deceased alive on October 26, 1960 , and that death occurred at 3:30 A. M., from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter J. Pijanowski</i>				22b. DATE 10/26/60			
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-/Blight, Inc. 6009 Harford Rd. Balto. 14, Md.				25a. REC'D BY REGISTRAR NOV 1 '60		25b. REGISTRAR'S SIGNATURE <i>Charles E. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11097

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11077

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HOWARD ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHADY NOOK NURSING HOME		d. STREET ADDRESS 126 COLLEGE AVE	
3. NAME OF DECEASED (Type or print) First Middle Last SOPHIA COOK HAMMOND		4. DATE OF DEATH Month Day Year OCT. 27 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMBROIDRY		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME FRANK LLOYD HAMMOND		14. MOTHER'S MAIDEN NAME FANNIE MARIA COOK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MISS ELEANOR M. HAMMOND MD.		Address 126 COLLEGE AVE. ELLICOTT CITY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) Arteriosclerotic Cardio-Vascular Disease 4 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 10 1956 to October 27 1960 , that (I) (we) last saw the deceased alive on October 27 1960 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE William F. Cassaway		22b. DATE SIGNED 10/27/60	
22c. PHYSICIAN'S NAME (Type) William F. Cassaway M.D.		22d. ADDRESS Ellicott City, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/27/60	
23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEM.		23d. LOCATION (City, town, or county) (State) ELLICOTT CITY, MD	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Jones		25a. REC'D BY REGISTRAR OCT 31 '60	
ADDRESS CATONSVILLE, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

11057

OFFICIAL OF DEATH

11057

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11098

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11078

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14		d. STREET ADDRESS 3400 Puttyhill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOSEPH HANLON		First		Middle		Last		4. DATE OF DEATH 10 16TH 1960		Month		Day		Year							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 12, 1900		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Manfg.-Bedding		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DENNIS HANLON		14. MOTHER'S MAIDEN NAME MARY WALDON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-03-4789		INFORMANT Wife		Address 3400 Puttyhill Road #14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA. 153-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC FAILURE. ADENOCARCINOMA OF SIGMOID AN METASTATIC CARCINOMA - 16 MOS.		INTERVAL BETWEEN ONSET AND DEATH 2 days " "		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 15, 1959 to OCT. 16, 1960 that I last saw the deceased alive on OCT. 16, 1960 , and that death occurred at 11:50 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1200 ST. PETER ST. BALTO-2, MD		DATE SIGNED 10/18/60		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/20/60		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) BALTO MD		23. FUNERAL DIRECTOR'S SIGNATURE C. F. EVANS & SON		ADDRESS 8802 HARFORD RD		24a. REC'D BY REGISTRAR DATE OCT 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

11078

CERTIFICATE OF DEATH

11078

Salisbury

Salisbury County

Life

3400 Pottsville Road

3400 Pottsville Road

JOSEPH HUNTON

Male White

Jan. 12, 1900

Effort

Male - Bedding

Salisbury, Maryland

U.S.A.

3400 Pottsville Road

White

210-03-1789

no

Alfred E. Wilkinson, M. D.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11099
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11079

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN lb 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1610 N. Division Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle --- Last HARRIS, JR.				4. DATE OF DEATH Month October Day 5 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1925	
9. AGE (In years last birthday) 35		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Harris, Sr.				14. MOTHER'S MAIDEN NAME Mammie Porter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 213-12-8631		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, MODERATELY ADVANCED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA, BILATERAL (c) PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4+ DAYS 1 DAY							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FATTY INFILTRATION OF THE LIVER- Duration Unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from October 2, 1960 to October 5, 1960 , that (if we) last saw the deceased alive on October 5, 1960 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE 10/6/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson				25a. REC'D BY REGISTRAR DATE OCT 7 '60		25b. REGISTRAR'S SIGNATURE Charles E. Harris	

11670

CERTIFICATE OF DEATH

1968



1



11100

CERTIFICATE OF DEATH

11080

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penn.</u> b. COUNTY <u>York</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - White Hall RD 2 Mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Logansville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>75X-</u>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Emma</u> Last <u>Hendrickson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Horse Shoe Run, W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Sell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wotring</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Est. Crouse, White Hall RD #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/24</u> , 19 <u>60</u> , to <u>10/26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Herbert Mueller</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON</u> DATE SIGNED <u>10/26/60</u>	
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER, Jr</u>		<u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 28, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rose Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>York Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Goodling, Seven Valleys, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 31 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Robert S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11500

CERTIFICATE OF DEATH

11500

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

MADE BY THE REGISTRAR OF DEATHS, BALTIMORE, MD. 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
11101

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11081

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 3½ Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa				d. STREET ADDRESS Fox Croft School			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rebecca Middle M. Last Hickok				4. DATE OF DEATH Month 10 Day 20 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1891	
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 9 Hours 10 Min.		IF UNDER 24 HRS. Months 6 Days 9 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Fox Croft School		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John J. Hickok				14. MOTHER'S MAIDEN NAME Mary Ober			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 224-01-4964		17. INFORMANT J. Hambleton Ober	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease with hypertension DUE TO (c) 2 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6-8 mos.				INTERVAL BETWEEN ONSET AND DEATH 6-8 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Middleburg, Va.				(County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 6-6-60 19, to 10-20-60 19, that (I) (we) last saw the deceased alive on 10-20-60 19, and that death occurred at 4:30 from the causes and on the date stated above.							
22a. SIGNATURE Warde B. Allan				22b. DATE SIGNED 10-20-60			
22c. PHYSICIAN'S NAME (Type) Dr. Warde B. Allan				22d. ADDRESS 6 E. Eager St., Balto. 2, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/60		23c. NAME OF CEMETERY OR CREMATORY Fox Croft Cemetery		23d. LOCATION (City, town, or county) (State) Middleburg, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd, Balto. 12				25a. REC'D BY REGISTRAR DATE OCT 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11102

11082

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owings Mill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chattolonee Hill		e. STREET ADDRESS 1 Chattolonee Hill	
3. NAME OF DECEASED (Type or print) First Carolyn Middle Symington Last Hoffman		4. DATE OF DEATH Month Oct. Day 15 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2 1870
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Hopkins Janey		14. MOTHER'S MAIDEN NAME Caroline Symington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT William G. Hoffman 3rd Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO arterio-sclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 16 1936 to Oct 15 1960 that (I) (not) last saw the deceased alive on Oct 13 1960 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Palmer F.C. Williams		22b. DATE SIGNED Oct 13 1960	
22c. PHYSICIAN'S NAME (Type) PALMER F.C. WILLIAMS		22d. ADDRESS Pikesville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-18-60	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City, town, or county) (State) Pikesville Md.
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE OCT 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11062

CERTIFICATE OF DEATH

11102

James H. Henson

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CERTIFICATE OF DEATH

11103

11083

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 152 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		(13)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2705 Pelham Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERMAN		First W.		Middle HOFFMAN		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 24, 1933	
9. AGE (In years last birthday) 26		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Electronics		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Herman C. Hoffman				14. MOTHER'S MAIDEN NAME Emily King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 6/3/54; 5/25/56 218-30-5412		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 200.1 IMMEDIATE CAUSE (a) LYMPHOSARCOMA, GENERALIZED CHRONIC ADHESIVE PERICARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 1960 to Oct. 19, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 19, 1960 , and that death occurred at 10:22 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Fredrick S. Donaldson				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/20	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTO, 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 24/60		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, 4210 Belair Rd. Balto. Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 24 '60	
						25b. REGISTRAR'S SIGNATURE Orlana S. Hanna	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 1 mo. 21 da. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Tr. School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland d. STREET ADDRESS P. O. box 485, 13 Morgan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Wayne Last HOLLOWAY		4. DATE OF DEATH Month 10 Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/60
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		11. BIRTHPLACE (State or foreign country) Maryland Harford Co.	12. CITIZEN OF WHAT COUNTRY? U.S.A./
13. FATHER'S NAME Roy Eugene Wilder		14. MOTHER'S MAIDEN NAME Anna Frances Holloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 752X IMMEDIATE CAUSE (a) Aspiration Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Spinal Meningitis DUE TO (c) Hydrocephalus			INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 5 days 7/12/60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/25 1960 , to 10/21 1960 , that (I) (we) last saw the deceased alive on 10/21 1960 , and that death occurred at 9a M., from the causes and on the date stated above.			
22a. SIGNATURE Edward J. Mathews		22b. DATE SIGNED 10-21-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Rosewood State Training School (Box 18) Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Oct 27, 1960	23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery	23d. LOCATION (City, town, or county) (State) Owings Mills Md
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Thine, Sins Rusttown		25a. REC'D BY REGISTRAR DATE NOV 1 '60	
		25b. REGISTRAR'S SIGNATURE Arthur P. H...	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11085									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McDonogh					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 2V01-4				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McDonogh School					d. STREET ADDRESS 2225 Orleans St.				
3. NAME OF DECEASED (Type or print) Robert B.T. Holmes, Jr.					4. DATE OF DEATH Month Oct. Day 3 Year 1960				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1913		9. AGE (In years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY McDonogh School		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Holmes					14. MOTHER'S MAIDEN NAME Sarah Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes					16. SOCIAL SECURITY NO. W.W.II 218-07-3726				
17. INFORMANT McDonogh School Records					Address Samuel Holmes, 2225 Orleans St., Balto. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m. none			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE D.D. Caples					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) D. D. Caples, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED 10-4-60				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/60		22c. NAME OF CEMETERY OR CREMATORY Mt Talor Cemetary		22d. LOCATION (City, town, or country) (State) Blackstork S.C.			
23. FUNERAL DIRECTOR Elroy O. Wilson, 1000 Brentley Ave., Balto.						24a. REC'D BY REGISTRAR OCT 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. House	

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION

11105

11084

AND AN EXAMINER'S CERTIFICATE OF DEATH

RESIDENCE

DATE OF DEATH

STATE OF NEW YORK

IN THE CITY OF NEW YORK

DECEASED

NAME

AGE

RESIDENCE

DATE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11106

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11086

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>14 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>115 E. Chesapeake Avenue</u>				d. STREET ADDRESS <u>115 Chesapeake Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Holifield</u> Last <u>Holifield</u>				4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7 1915</u>	
9. AGE (In years last birthday) <u>45 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Perry Co., Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jim Holifield</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-30-4117</u>		17. INFORMANT <u>Luther Holifield</u> Address <u>241 Silver Court Balto. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William A. Jackson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William A. Jackson</u>				DATE SIGNED <u>10/23/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson</u> ADDRESS <u>Funeral Home Inc. 916 Pa. Ave.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>10/26/60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11107

CERTIFICATE OF DEATH

11087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Audrey Ruth Middle Hoshall Last		4. DATE OF DEATH Month October Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1919
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 2 Days 10	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner		10b. KIND OF BUSINESS OR INDUSTRY L.Grief Bros.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Harry Tracey.	
14. MOTHER'S MAIDEN NAME Birdie Wilson.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 	
16. SOCIAL SECURITY NO. 		17. INFORMANT John Raymond Hoshall, Lutherville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 174X Carcinoma of Uterus DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) starvation			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August , 19 60 , to October 26 , 19 60 , that I last saw the deceased alive on October 26th , 19 60 , and that death occurred at 2 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George H. Cross		M.D. 28 W. 20th St Oct. 27th 1960	
PHYSICIAN'S NAME (Type) George H. Cross			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/29/60	22c. NAME OF CEMETERY OR CREMATORY Stablersville, Md	22d. LOCATION (City, town, or county) (State) Balto Co, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan - 3818 Roland Ave		24a. REC'D BY REGISTRAR DATE OCT 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MEDICAL CERTIFICATION

1685

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111088
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11088
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Manor</u> c. LENGTH OF STAY IN lb <u>6 wks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XTIMONIUM.</u> d. STREET ADDRESS <u>1506 DULANEY VALLEY RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Dickinson</u> Last <u>Humphrey</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1960</u>																			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26th 1879</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>											
13. FATHER'S NAME <u>Charles E Dickinson</u>				14. MOTHER'S MAIDEN NAME <u>Jola Virginia Steiner</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Eliz H. Hallow</u> Address <u>1506 Dulaney Rd.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>pyelonephritis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 years</u>											
												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pyelonephritis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> 19 <u>60</u> to <u>10/15</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>10/15</u> 19 <u>60</u> and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.																							
22a. SIGNATURE <u>Robert C Duvall</u> M.D.				22b. DATE SIGNED <u>10/17/60</u>				22c. PHYSICIAN'S NAME (Type) <u>Robert C. Duvall, M.D.</u>				22d. ADDRESS <u>101 W. READ ST. BALTO-MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>10-18-60</u>				23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>				23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOK-TOWSON, INC. TOWSON 4 MD</u>				ADDRESS				25a. REC'D BY REGISTRAR <u>OCT 18 '60</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>											

11088

11108



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11089

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
3. NAME OF DECEASED (Type or print) <u>Aaron</u> First Middle Last <u>Iskow</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Moses Iskow</u>		14. MOTHER'S MAIDEN NAME <u>Dora</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Herman Iskow</u>		Address <u>10230 Conover Dr, SSpg., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>44+2X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Hypertensive Cardio-Vascular Renal Disease</u> DUE TO <u>10yr</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12mo</u> <u>10yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>5-27, 1960</u> , to <u>10-9, 1960</u> , that I last saw the deceased alive on <u>10-8, 1960</u> , and that death occurred at <u>6:15A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D. <u>6209 Frederick Ave.</u> <u>10/9/60</u> PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> <u>Baltimore-28</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 10, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>D. C. Lodge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11110

11090

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. LENGTH OF STAY IN 1b 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home				d. STREET ADDRESS 1906 Jefferson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK WILLIAM JOHN		First Middle Last		4. DATE OF DEATH October 30, 1960		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1982		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-ret.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leopold John				14. MOTHER'S MAIDEN NAME Don't know			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-07-3512		17. INFORMANT Address Roland W. John 1906 Jefferson Road-22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 DUE TO Arteriosclerotic Cardiovascular Disease - Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to Oct 30 , 19 60 , that (I) (we) last saw the deceased alive on Oct 30 , 19 60 , and that death occurred 12 P. M. from the causes and on the date stated above.							
22a. SIGNATURE John E. Gessner				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 10-31-60	
22c. PHYSICIAN'S NAME (Type) JOHN E. GESSNER				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/60		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 3 '60	
				25b. REGISTRAR'S SIGNATURE Charles E. Hume			

11690

CENTRAL OF DEATH

11110



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11091

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balta			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 62 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (14)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2617 Canterbury Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CIARENCE Middle F. Last JOHNSON				4. DATE OF DEATH Month October Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1892	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain-		10b. KIND OF BUSINESS OR INDUSTRY Tugboat		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Johnson				14. MOTHER'S MAIDEN NAME Annie E. White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 212-07-7709		17. INFORMANT Clinical Records, VAH, Baltimore 18, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO BRONCHOGENIC CARCINOMA, LEFT LUNG AND ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BENIGN PROSTATIC HYPERTROPHY							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 11, 1960 to October 12, 1960 , that (I) (we) last saw the deceased alive on October 12, 1960 , and that death occurred at A. M. , from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/12/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Funeral Home				ADDRESS 5305 Harford Rd. Baltimore 14, Md.		25a. REC'D BY REGISTRAR Oct 13 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Kline			

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CONFIRMATION OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> <u>HOLY BEACH RD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>	c. LENGTH OF STAY IN 1b <u>12 YRS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOLY BEACH RD.</u> *	
d. NAME OF HOSPITAL OR INSTITUTION. (If not in hospital, give street address) <u>HOLY BEECH RD.</u>		d. STREET ADDRESS <u>MIDDLE RIVER</u> 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>K.</u> Last <u>JUNUSKA</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 29 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COAT-MAKER</u>	
11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles JUNUSKA</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-7590A</u>	
17. INFORMANT <u>Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart dis</u> (c) <u>420.0</u> DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>OCT 25 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WEST HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BELAIR RD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Lachowich</u>		ADDRESS <u>637 Washington</u>	
24a. REC'D BY REGISTRAR <u>OCT 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

DATE SIGNED

10-23-60

5013

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor discoloration and faint, illegible markings. Two dark, irregular holes are punched through the paper, one near the top and one near the bottom, suggesting it was once part of a bound volume. The overall tone is warm and historical.

11113

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11093

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Green Spring Manor apt 201</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Forleigh Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Karl</u> Middle <u>Kahn</u> Last <u>Kahn</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28 1897</u>
9. AGE (In years lost birth day) <u>63</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY <u>Finance</u>	11. BIRTHPLACE (State or foreign country) <u>Charles Town W Va</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S</u>
13. FATHER'S NAME <u>William Kahn</u>		14. MOTHER'S MAIDEN NAME <u>Jda Weil</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-05-3751</u>	
17. INFORMANT <u>Mrs. Alice b Kahn</u> Address <u>Green Spring Manor apt 201</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Vascular Accident (left) - with MI</u> DUE TO <u>hypertensive C.V. D & arterial sclerosis.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease.</u> DUE TO (c) <u>years</u> INTERVAL BETWEEN ONSET AND DEATH <u>8-27-60</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 27 1960</u> to <u>Oct 8 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 8 1960</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard J. Cohen</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DR. BERNARD J. COHEN</u>		22d. ADDRESS <u>Home Gardens - Apt. 3501 St. Paul</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/10/60</u>	<u>Ches. Shalom Cemetery</u>	<u>6100 O'Donnell St MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>David R Martin</u>		25a. REC'D BY REGISTRAR <u>OCT 17 '60</u>	
ADDRESS <u>1902 Eutaw place</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
<u>Balt MD</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11113

CERTIFICATE OF DEATH

11003

CHIEF TWA

COX

Reg. Dist. No.

11112

11095

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b 6 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8402 Birchwood Road				d. STREET ADDRESS 6611 Baythorne Road.			
3. NAME OF DECEASED (Type or print) Marie		First (none)		Middle Kaiser		Last Oct. 25 19 60	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1894	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Austria-Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Kaufmann				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Michael Kaiser, 6611 Baythorne Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Housewife Aden 153-1 DUE TO Metastases of above Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 1960 to October 25, 1960 , that I last saw the deceased alive on October 25, 1960 , and that death occurred at 5:15 P.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) 6821 Reisterstown Road DATE SIGNED 10/26/60 ACTUAL SIGNATURE Cecil Rudner M.D. Cecil Rudner, M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 1960		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Vernon Lemmon				ADDRESS 4611 Park Heights, Balto.		24a. REC'D BY REGISTRAR DATE 2 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

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Date of Birth 1911/11/11		Date of Death 1911/11/11	
Place of Birth Baltimore, Md.		Place of Death Baltimore, Md.	
Name of Deceased John Doe		Name of Informant John Doe	
Sex Male		Race White	
Age 11		Cause of Death ...	
Occupation ...		Date of Report ...	
Signature of Informant ...		Signature of Physician ...	

VS. A15ME
5M 7/S9

W. J. T. Jones

Film #293-10/20/60 - Two for one certificate -
Medial certification changed - *WAB*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH



Dr. [Name], Boston 02118



[Handwritten signature]

Witnessed, [Name]

1-12-1960

607-1-50

may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

111116
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11096

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>M</u> Last <u>Keyser</u>				4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/6/1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>22</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Walter</u>				14. MOTHER'S MAIDEN NAME <u>Emma Greening</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mr Henry A. Keyser</u> Address <u>Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Caong</u> DUE TO <u>Arteriosclerosis</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Age</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>Ulcer</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 14, 1960</u> to <u>Oct 22, 1960</u> that (I) (we) last saw the deceased alive on <u>Oct 12, 1960</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Cliff Ratliff, Sr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/22/60</u>							
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, SR.</u> 22d. ADDRESS <u>4605 Edmondson Ave #29</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/25/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Edmondson & Longwood Sts.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> ADDRESS <u>1001 Hollins St.</u>							
25a. REC'D BY REGISTRAR <u>Oct 24 60</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11098

Item 6 Film 9274 10-31-60 et

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLINTON Middle E Last KIRBY		4. DATE OF DEATH Month October Day 22 Year 1960	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20 1906
9. AGE (In years lost birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT KIRBY		14. MOTHER'S MAIDEN NAME CATHERINE THOMPSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11 213-10-2712	
17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL HEMORRHAGE DUE TO RUPTURE OF THE ESOPHAGUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL HEMORRHAGE - 4 DAYS			
INTERVAL BETWEEN ONSET AND DEATH 26 HOURS UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from October 19, 1960 to October 22, 1960 that (X) (we) last saw the deceased alive on October 22, 1960 , and that death occurred at 4:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles E. Rowan		22b. DATE SIGNED 10-22-60	
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN		22d. ADDRESS M.D. VAH BALTO 18 MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-25-60	
23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEMORIAL GARDENS		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		25a. REC'D BY REGISTRAR OCT 24 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Rowan		25c. REGISTRAR'S NAME Charles E. Rowan	

Liberty Heights Ave Baltimore Maryland

11002

CENTRAL C-CLARK

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. This page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

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111119

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u> X	
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>		d. STREET ADDRESS <u>Kenmar Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kenmar Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Stewart</u> Last <u>Knott</u>		4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Greenskeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henery Knott</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Shorb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>214-20-8368</u>	
17. INFORMANT <u>Mrs. Rose Hoff</u>		Address <u>Pikesville 8, Md.</u> <u>201 Hawthorne Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. est.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>none</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. Caples, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>10-24-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 25, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Newell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 26 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

11120

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 11 FilmG273 10-20-60 et
CERTIFICATE OF DEATH

11100

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3V01.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME.</u>				d. STREET ADDRESS <u>6801 Duluth Avenue</u> <u>329 HARLEM AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>M</u> Last <u>KOPONEC</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>8</u> Year <u>1960</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>		IF UNDER 24 HRS. Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Boat-Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>!</u>				14. MOTHER'S MAIDEN NAME <u>!</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>!</u>				16. SOCIAL SECURITY NO. <u>216-10-1182</u>			
17. INFORMANT <u>Mrs Thoma Dobishy</u>				Address <u>6801 Duluth Ave.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis generalized</u> DUE TO <u>known</u> (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Age</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Age</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>---</u> p. m. <u>---</u> 19 <u>---</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) <u>---</u>				(County) <u>---</u>		(State) <u>---</u>	
21. I certify that I attended the deceased from <u>3/25</u> , 19 <u>53</u> , to <u>10/8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/3</u> , 19 <u>60</u> , and that death occurred at <u>4:40</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 EDMONDSON AVE.</u> DATE SIGNED <u>---</u>							
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D. <u>---</u>							
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u> <u>BALTIMORE 29, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-11-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Dabrowski</u>				ADDRESS <u>1001 Dundell Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

CERTIFICATE OF DEATH

6801 Duluth ave.
Balto.

Inc 3-6630

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11121

11101

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle - Last KOTCH				4. DATE OF DEATH Month OCTOBER Day 9 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/96	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Riviter		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Freeland, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kotch				14. MOTHER'S MAIDEN NAME Anna Greshke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-09-9470		17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO 183X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CARCINOMATOSIS PROBABLE LUNG DUE TO (c) TUBERCULOSIS PULMONARY FAR ADVANCED							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOCYTOPENIA PURPURA							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 29 , 1960, to Oct. 9 , 1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 9 1960 , and that death occurred at 1:20AM from the causes and on the date stated above.							
22a. SIGNATURE Thomas R. Hood				22b. DATE SIGNED 10/9/60		22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-13-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR OCT 11 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	
23d. LOCATION (City, town, or county) (State) Baltimore, Maryland				23e. ADDRESS 6009 Harford Road Baltimore, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the funeral director. The attending physician and completely filled in the funeral director. After this certificate has been signed by the attending physician and completely filled in the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11111

UNITED STATES OF AMERICA

11111

Belgium

1911

1911

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John D. ...

John D. ...

John D. ...

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11043

CERTIFICATE OF DEATH

Reg. Dist. No. 11102

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b 12 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Old Hanover Road				d. STREET ADDRESS Old Hanover Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Louise First Kreamer Last				4. DATE OF DEATH Month Oct. Day 11 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1878		9. AGE (In years last birthday) yrs. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Box Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Kreamer				14. MOTHER'S MAIDEN NAME Louise Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss. Barbara Kreamer Address Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart Failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 week years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 7, 1960 , to Oct 11, 1960 , that I lost s/he the deceased on Oct 10, 1960 , and that death occurred at 7:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles E. McWilliams M.D.				ADDRESS (Street, city or town, state) 11904 Reisterstown Rd, Reisterstown, Md. DATE SIGNED Oct 11, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/60		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Nusbaum ADDRESS Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '60		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EXHIBIT FROM Maryland

CERTIFICATE OF DEATH

11023

11023

DATE OF DEATH		11-11-1918	
PLACE OF DEATH		HOME	
DECEASED		JOHN J. JONES	
AGE		45	
SEX		MALE	
RACE		WHITE	
BIRTH		JAN 15 1873	
PLACE OF BIRTH		BALTIMORE, MD	
OCCUPATION		LABORER	
CAUSE OF DEATH		PNEUMONIA	
PERIOD OF ILLNESS		10 DAYS	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. SMITH	
SIGNATURE OF WITNESSES		J. H. SMITH, J. D. JONES	
SIGNATURE OF DECEASED		JOHN J. JONES	
SIGNATURE OF REGISTRAR		J. H. SMITH	
DATE OF REGISTRATION		11-11-1918	
PLACE OF REGISTRATION		BALTIMORE, MD	
OFFICIAL USE			
REMARKS			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF WITNESSES			
SIGNATURE OF DECEASED			
SIGNATURE OF REGISTRAR			
DATE OF REGISTRATION			
PLACE OF REGISTRATION			
OFFICIAL USE			
REMARKS			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF WITNESSES			
SIGNATURE OF DECEASED			
SIGNATURE OF REGISTRAR			
DATE OF REGISTRATION			
PLACE OF REGISTRATION			
OFFICIAL USE			
REMARKS			

11103
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTIMORE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural - Rosedale		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1607 Odell Ave.		unknown	
3. NAME OF DECEASED (Type or print)		First		Middle	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Czechoslovakia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		4. DATE OF DEATH	
John Kriss		Unknown		Month	
				October	
				Day	
				20	
				Year	
				19 60	
8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
4-6-1876		84 yrs.		Months	
				Days	
				Hours	
				Min.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		John Kriss		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT	
No		none		Address	
				Anton C. Kriss - 1607 Odell Ave. (6)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		-3 wks			
422-1 DUE TO		Pulmonary Edema			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
DUE TO		Arteriosclerotic C.V. Disease		12 yrs	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		(City or town)	
p. m.				(County)	
19				(State)	
21. I certify that I attended the deceased from Oct 7, 1948, to Oct 10, 1948, that I last saw the deceased alive on Oct 6, 1948, and that death occurred at 2 A. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
J. Ralph Horky		Churchville, Md.		10/21/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		10-22-60		Holy Redeemer Cemetery	
				Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
J. Ralph Horky		1211 Chesaco Ave.		OCT 25 1960	
				24b. REGISTRAR'S SIGNATURE	
				Arthur L. Hanks	

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11123

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11104

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write Baltimore) RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write Baltimore) RURAL and give nearest town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home		d. STREET ADDRESS 2929 Guilford Ave. #18	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dr. Constant J. Kryzanowsky		4. DATE OF DEATH Month Day Year Oct. 21, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1881
9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor of Mech. Eng. & Physicist		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Constant J. Kryzanowsky XXXXXXXXXXXXXX		14. MOTHER'S MAIDEN NAME Martha Feldt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-18-8893	
17. INFORMANT Mattie L. Furness		Address 2929 Guilford Ave. #18	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Multiple Cerebral Vascular Accidents. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Disease		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 Sept 1960 to 21 Oct 1960 that (I) (we) lost saw the deceased alive on 10/20/60 and that death occurred 1225A from the causes and on the date stated above.		22a. SIGNATURE W E McGrath MD	
22b. DATE SIGNED 10/21/60		22c. PHYSICIAN'S NAME (Type) W E. McGrath MD	
22d. ADDRESS 1303 Frederick Rd Catonsville 28 Md		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/22/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
25a. REC'D BY REGISTRAR DATE OCT 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Item 18 Film 274 11-1-60 ans

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Items 10, 11, 12 Film 273 10-20-60 at

11105

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Baltimore 34**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **9912 Finney Drive**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Baltimore 34**
d. STREET ADDRESS **9912 Finney Drive**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) **DAVID M. KURTZ**
4. DATE OF DEATH **October 12 1960**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **3-3-1898** 9. AGE (In years last birthday) **62** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **Shippensburg, Penna.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Samuel B. Kurtz** 14. MOTHER'S MAIDEN NAME **Agnes Smith**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **yes** 16. SOCIAL SECURITY NO. **Van Seyoc Funeral Home - 112 W. King St. /** 17. INFORMANT **Shippensburg, Pa.** Address **INTERVAL BETWEEN ONSET AND DEATH**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Arteriosclerotic heart disease**
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ et work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE **W. Bradley King, Jr., M.D.** M.D. DATE SIGNED **10/13/60**

EXAMINER'S NAME (Type) **W. Bradley King, Jr., M.D.** Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **10/13/60** 22b. DATE THEREOF **Spring Hill** 22c. NAME OF CEMETERY OR CREMATORY **Shippensburg, PA** 22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR **W. J. Tickner & Sons. Balto. Md** ADDRESS **OCT 14 '60** 24a. REC'D BY REGISTRAR **Carlton S. Kraus** 24b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11106**

11125

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOVANS		c. LENGTH OF STAY IN 1b 25 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOVANS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6326 SMITH CT.				d. STREET ADDRESS 6326 SMITH CT. 1			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET (MARGUERITE) LANDERS				4. DATE OF DEATH Month Day Year 10/24/60 19			
5. SEX F	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1899	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILIES		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME ISAAC THOMAS				14. MOTHER'S MAIDEN NAME ROSE COLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 21220-9258		17. INFORMANT Address JESSE LANDER-6326 SMITH CT.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) Sudden (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/24/60			
EXAMINER'S NAME (Type) Charles F O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/60		22c. NAME OF CEMETERY OR CREMATORY Pleasant Rest		22d. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Blumenthal				ADDRESS 1701 M^cCallister St. Balto. Md.		24a. REC'D BY REGISTRAR DATE OCT 27 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11107
Reg. Dist. No.

11126

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr. 4mth. 6dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1011 Light Street			
3. NAME OF DECEASED (Type or print) First Isaac Middle Mitchell Last Lawrence				4. DATE OF DEATH Month Oct Day 16 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1877		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Unknown) ret'd		10b. KIND OF BUSINESS OR INDUSTRY Boat Builder		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Leslie Lawrence				14. MOTHER'S MAIDEN NAME Esther Anne Bozman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 265-09-2482A		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Fracture of left femur						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell on 9-26-60 sustaining an intertrochanteric fracture of the left femur.					
20c. TIME OF INJURY Hour 9:15 P. m. 9-26-60		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. M. Kieffer M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Oct 17/1960			
EXAMINER'S NAME (Type) GEO. M. KIEFFER M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-19-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) 5829 Ritchie Highway, Zone 25	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE OCT 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11107

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11156

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. RACE [REDACTED]	
5. DATE OF DEATH [REDACTED]		6. TIME OF DEATH [REDACTED]	
7. PLACE OF DEATH [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. SIGNATURE OF EXAMINER [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF CORONER [REDACTED]	
13. SIGNATURE OF JURY [REDACTED]		14. SIGNATURE OF JURY [REDACTED]	
15. SIGNATURE OF JURY [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]	
21. SIGNATURE OF JURY [REDACTED]		22. SIGNATURE OF JURY [REDACTED]	
23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]	
27. SIGNATURE OF JURY [REDACTED]		28. SIGNATURE OF JURY [REDACTED]	
29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]	
33. SIGNATURE OF JURY [REDACTED]		34. SIGNATURE OF JURY [REDACTED]	
35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]	
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51. SIGNATURE OF JURY [REDACTED]		52. SIGNATURE OF JURY [REDACTED]	
53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
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59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]	
63. SIGNATURE OF JURY [REDACTED]		64. SIGNATURE OF JURY [REDACTED]	
65. SIGNATURE OF JURY [REDACTED]		66. SIGNATURE OF JURY [REDACTED]	
67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]	
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71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
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75. SIGNATURE OF JURY [REDACTED]		76. SIGNATURE OF JURY [REDACTED]	
77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]	
81. SIGNATURE OF JURY [REDACTED]		82. SIGNATURE OF JURY [REDACTED]	
83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
85. SIGNATURE OF JURY [REDACTED]		86. SIGNATURE OF JURY [REDACTED]	
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93. SIGNATURE OF JURY [REDACTED]		94. SIGNATURE OF JURY [REDACTED]	
95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]	
99. SIGNATURE OF JURY [REDACTED]		100. SIGNATURE OF JURY [REDACTED]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11108**

11040

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 Alabama Ave.				d. STREET ADDRESS 3000 Alabama Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary C. Lee				4. DATE OF DEATH Month Day Year 10 6 19 60					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/2/82			
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George Hopkins				14. MOTHER'S MAIDEN NAME Elizabeth Bluford					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes, give war or dates of service No				16. SOCIAL SECURITY NO.		INFORMANT Mrs. Fredericks			
15. ADDRESS 3000 Alabama Ave.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interventricular P. V. D DUE TO (c) Senile Dementia				INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 10, 1960, to Oct 6, 1960 that I last saw the deceased alive on Oct 5, 1960, and that death occurred at 9 M, from the causes and on the date stated above. ACTUAL SIGNATURE Paul Schmied M.D. ADDRESS (Street, city or town, state) DATE SIGNED 10/6/60 PHYSICIAN'S NAME (Type) Paul Schmied - Baltimore (30) Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/60		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave. # 30				24a. REC'D BY REGISTRAR DATE OCT 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11080

CERTIFICATE OF DEATH



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11127

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11109

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #20 Summerfield Road				d. STREET ADDRESS #20 Summerfield Road			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK YORK LLOYD				4. DATE OF DEATH Month Day Year October 17, 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1906	
9. AGE (In years lost birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Crown Oil		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Howard L. Lloyd				14. MOTHER'S MAIDEN NAME Sarah Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII				16. SOCIAL SECURITY NO. 219-01-2675			
17. INFORMANT Louise S. L. Lloyd				Address #20 Summerfield Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon with metastases, generalized DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ***** 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ***** 19 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ***** 20f. (City or town) (County) (State) *****							
21. I certify that I attended the deceased from 19 50 to October 16, 1960 , that I last saw the deceased alive on October 16, 1960 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Millard T. Traband, Jr.				ADDRESS (Street, city or town, state) 5101 Gwynn Oak Ave. Baltimore, 7, Md.			
DATE SIGNED 10.18.60							
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 19, 1960		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR OCT 19 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	
ELLSWORTH ARMACOST 4600 Liberty Heights							

MEDICAL CERTIFICATION

11187

CERTIFICATE OF DEATH

11187

Woodman

Woodman, Maryland

440 Summerfield Road

440 Summerfield Road

FRANK YORK LLOYD

October 17, 1900

Male

Oct. 17, 1900

Seafarer

Covered

Washington D.C.

Howard Lloyd

Seafarer

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1919-01-1918

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Oct. 19, 1900

Woodman, Maryland

ELLIS OR IN ARMADOST AND LIVERY HOTEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11128
11110
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>city</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catm Ridge Nursing Home</u>		d. STREET ADDRESS <u>901 McAleer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Lydia A. Ludloff</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Orlando Wilkinson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Patton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Martha W. Cofiell, 901 McAleer Court</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>450-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>age</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> 19 <u>60</u> to <u>10/19</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>10/17</u> 19 <u>60</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff, Jr.</u>		22b. DATE SIGNED <u>10/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		22d. ADDRESS <u>4605 Edmond Ave #29</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-22-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Cliff Ratliff, Jr.</u>			

1113

CENTRAL CITY OF DEATH

1113

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11130

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11112

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 5 1/2 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle B. Last MANOR		4. DATE OF DEATH Month 10 - Day 28 - Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-73
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JACOB NAYLOR		14. MOTHER'S MAIDEN NAME ELIZA DRAKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) ARTERIO SCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-4-60 to 10-28-1960 , that (I) (we) last saw the deceased alive on 10-27-1960 , and that death occurred at 12:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 10-28-60	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-31-60	
23c. NAME OF CEMETERY OR CREMATORY SAINT MARKS		23d. LOCATION (City, town, or county) (State) PETERSVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE B. HILL FULTON		ADDRESS BRUNSWICK, MARYLAND	
25a. REC'D BY REGISTRAR NOV 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

11111

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
111131
11113
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor		d. STREET ADDRESS Joppa	
3. NAME OF DECEASED (Type or print) Esther Saucer Masson		4. DATE OF DEATH October 28, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ? Saucer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Stevenson Masson		Address Joppa, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO HYPERTENSIVE CV DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 10 YRS. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 22 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) OSTEOARTHRITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-28, 1957 to OCT. 28, 1960 , that (I) (we) last saw the deceased alive on OCT. 28, 1960 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE John F. Schaeffer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFFER		22d. ADDRESS 401 RANDOM RD. BALTO 29 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Tuckner & Sons		25a. REC'D BY REGISTRAR Balto Md	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE OCT 31 '60	

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11113

CERTIFICATE OF DEATH

1913

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1913

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11114

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 36 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROY Middle MATTHEWS Last MATTHEWS		4. DATE OF DEATH Month October Day 22 Year 19 60	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 16, 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during mast of working life, even if retired) PLUMBER'S HELPER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MATTHEWS		14. MOTHER'S MAIDEN NAME EMMA COLLINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 217-09-1492	
17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 MALNUTRITION DUE TO Conditions, if any, which gave rise to immediate cause (b) FATTY LIVER cause (c), stating the underlying cause lost. CARDIAC ARRITHMIA INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 25 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD HEAL PULMONARY TUBERCULOSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 16, 1960 to October 22, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 22, 1960 , and that death occurred at 11:50 a.m., from the causes and on the date stated above.			
22a. SIGNATURE <i>M. Lawrence Rubin</i>		22b. DATE SIGNED 10-23-60	
22c. PHYSICIAN'S NAME (Type) M. LAWRENCE RUBIN, M.D.		22d. ADDRESS VAH, BALTIMORE, MD. - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 24, '60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Charles B Lewis Funeral Home		25a. REC'D BY REGISTRAR OCT 27 '60	
ADDRESS 1639 N Broadway Baltimore, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kross</i>	

11111

11111

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11115

Reg. Dist. No.

11133

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowley's Quarters</u>		c. LENGTH OF STAY IN 1b <u>Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seneca Park Rd.</u>			d. STREET ADDRESS <u>Rt. 16 Box 247 Ebenezer Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William H. Messenger</u>			4. DATE OF DEATH Month Day Year <u>October 4, 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1904</u>		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Highway</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>John Messenger</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Draayer</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>Mrs. Myrtle M. Messenger Rt. 16 Box 247</u> (20)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chase, Md.</u>	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M.B. Davis</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-8-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u>	
22d. LOCATION (City, town, or county) <u>Chase, Md.</u>		22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>			24a. REC'D BY REGISTRAR DATE <u>OCT 6 '60</u>		
24b. REGISTRAR'S SIGNATURE <u>Chase, Md.</u>			24c. (State)		

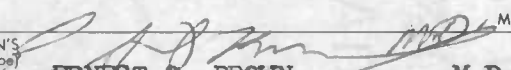
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

111134

11116

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
f. STREET ADDRESS 1028 WILMINGTON AVENUE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last WILLIAM A. MEYER		4. DATE OF DEATH Month Day Year October 21 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 22 1908		9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CITY OF BALTIMORE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OTTO C. MEYER				14. MOTHER'S MAIDEN NAME LOUISE ULMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11 215-05-6313		17. INFORMANT Address CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SARCOMA, METASTATIC, INVOLVING LIVER DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMACIATION						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 18, 1960 , to October 21, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 21 1960 , and that death occurred at 7:25 p.m. , from the causes and on the date stated above.							
22a. SIGNATURE  ERNEST O. BROWN				22b. DATE SIGNED 10-21-60		22c. PHYSICIAN'S NAME (Type) M.D. VAH BALTO 18 MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) EMERGENCY Removal		23b. DATE THEREOF 10/24/60		23c. NAME OF CEMETERY OR CREMATORY SAINT MARY'S CEMETERY		23d. LOCATION (City, town, or county) (State) KINGSTON NEW YORK	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc.				25a. REC'D BY REGISTRAR North & Penna. Aves Baltimore, Md.		25b. REGISTRAR'S SIGNATURE Oct 24 '60	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11135

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11117

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 30 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ISAAC Middle --- Last MIDGETT		4. DATE OF DEATH Month October Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Winslow Midgett		14. MOTHER'S MAIDEN NAME Matilda Crooms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 86-10-1900	
17. INFORMANT VAH, Baltimore 18, Maryland FORT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO BRONCHOGENIC CARCINOMA, RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162-1 (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Acute Membranous Colitis. (b) 2. Arteriosclerosis, marked, generalized. (c) 3. Benign Prostatic Hypertrophy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 28, 1960 to October 19, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/19 19 60 , and that death occurred at 2:55 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson		22b. DATE SIGNED 10/19/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTO. 18 MD, FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St.		25. REC'D BY REGISTRAR OCT 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111136

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

111118

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Baltimore	
f. STREET ADDRESS 6028 Moorehead Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle W Last MOESTA		4. DATE OF DEATH Month October Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Rudolph Moesta		14. MOTHER'S MAIDEN NAME Martha Bach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 716-09-2252	
17. INFORMANT Clin. Rec., VAH Balto 18, Md Ft Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION MULTIPLE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (b) PULMONARY EDEMA (c) ARTERIOSCLEROTIC HEART DISEASE ACUTE HEMORRHAGIC NECROSIS PANCREAS BENIGN PROSTATIC HYPERTROPHY		INTERVAL BETWEEN ONSET AND DEATH 2 Days 1 Day unknown 1 day unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if) (this hospital) attended the deceased from October 3, 1960 to October 5, 1960 , that (i) (we) last saw the deceased alive on October 5, 1960 , and that death occurred at 2:10 A. M., from the causes and on the date stated above.			
22a. SIGNATURE FREDERICK S DONALDSON, M.D.		22b. DATE SIGNED 10/5/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S DONALDSON, M.D.		22d. ADDRESS VAH Balto 18, Md Ft Howard Div.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Balto Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Inc		25a. REC'D BY REGISTRAR OCT 7 '60	
ADDRESS 6009 Harford Rd Balto 14,		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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CERTIFICATE OF DEATH

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Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111137

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

111119

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 51 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 2593 W. Baltimore St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle C Last MONTGOMERY		4. DATE OF DEATH Month October Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1904
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Tavern	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Montgomery		14. MOTHER'S MAIDEN NAME Anna L. Carey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-11 215-01-6217	
17. INFORMANT Clin. Rec. VAH Balto Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF TONGUE WITH METASTASIS TO NECK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALNUTRITION, ANEMIA			
INTERVAL BETWEEN ONSET AND DEATH 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 17, 1960 to Oct. 28, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 28, 1960 , and that death occurred at P M, from the causes and on the date stated above.			
22a. SIGNATURE Lawrence D. Marcus		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS, M.D.		22d. ADDRESS VAH, Baltimore 18, Md. Fort Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-2-60	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		25a. REC'D BY REGISTRAR NOV 1 '60	
ADDRESS 5305 Harford Road, Balto. 14, Md.		25b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11120

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penwood Terrace		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penwood Terrace				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 10, Box 644, Thomas Lane				d. STREET ADDRESS Route 10, Box 644, Thomas Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last NAOMI LOUISE MOORE				4. DATE OF DEATH Month Day Year October 2, 19 60				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1909	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis L. Berends				14. MOTHER'S MAIDEN NAME Fredericka Broghammer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Address Harry E. Ritter 1925 Eastfield Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by Hanging - 9774X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Parkville, Md.		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Jack O Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-4-60		
EXAMINER'S NAME (Type) JACK O Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/60		22c. NAME OF CEMETERY OR CREMATORY Moreland Park		22d. LOCATION (City, town, or county) (State) Parkville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home Dundalk, Md.				24a. REC'D BY REGISTRAR OCT 6 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hume		

11139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (4) (Towson)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 4, (Towson) 35	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 W. Joppa Rd.		d. STREET ADDRESS 306 W. Joppa Road 1	
3. NAME OF DECEASED (Type or print) First T. Middle Gertrude Last Moran		4. DATE OF DEATH Month October Day 21 , Year 19 60	
5. SEX F.	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1877
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Chenoweth		14. MOTHER'S MAIDEN NAME Sarah Schwartz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Dora Coale		Address 306 W. Joppa Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO (b) Anterior Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Breast			INTERVAL BETWEEN ONSET AND DEATH 1 day 57 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 46 , to 21 Oct , 19 60 , that I last saw the deceased alive on 21 Oct , 19 60 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6701 York Rd Baltimore 22 Oct			
ACTUAL SIGNATURE Charles H. Reier M.D.		PHYSICIAN'S NAME (Type) Charles H. Reier M.D. Md. 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 24, '60	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.	22d. LOCATION (City, town, or county) (State) Towson, Balto. 4, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc.		ADDRESS 1050 York Rd.	24a. REC'D BY REGISTRAR DATE OCT 25 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11122

Reg. Dist. No.

11140

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GA ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN		0250-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN PINES				d. STREET ADDRESS 206 R. Avenue Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle M. Last MORRISSETT				4. DATE OF DEATH Month 10 - Day 15 - Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1887		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal Worker		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry MORRISSETT				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 321X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Hypertension, essential, severe DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 , 19____, to 10-15 , 19 60 , that I last saw the deceased alive on OCT 15 , 19 60 , and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Begun Berdum M.D. 5010 A Ritchie Hwy Baltimore MD DATE SIGNED OCT 20 '60							
ACTUAL SIGNATURE Begun Berdum		PHYSICIAN'S NAME (Type) Begun Berdum					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-19-60		22c. NAME OF CEMETERY OR CREMATORY Green Haven Cem		22d. LOCATION (City, town, or county) (State) Green Haven Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave				24a. REC'D BY REGISTRAR DATE OCT 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11183

CERTIFICATE OF DEATH

11183

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and no any event within 72 hours after death.

V5. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

Item 18 Film 274 11-9-60											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11141 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12304											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6003 Westwood Avenue						d. STREET ADDRESS 6003 Westwood Avenue					
3. NAME OF DECEASED (Type or print) First FLORENCE Middle MOSCIRELLA						4. DATE OF DEATH Month October Day 13 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 2, 1948		9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL GIRL				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST J MOSCIRELLA						14. MOTHER'S MAIDEN NAME FLORENCE FINNICK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT AUGUST J. MOSCIRELLA		Address 6003 WESTWOOD AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X DUE TO Interstitial pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER W. Bradley King, Jr., M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/13/60											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF OCT 17 1960		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM		22d. LOCATION (City, town, or country) (State) 4430 BELAIR RD MD			
23. FUNERAL DIRECTOR NAME (Type) Dippel Bros						ADDRESS 7110 Belair Rd.		24a. REC'D BY REGISTRAR DATE OCT 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

THE STATE
OF CALIFORNIA



1114

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

California

San Francisco

Charles

Charles

600 North 4th Avenue

600 North 4th Avenue

STANFORD

STANFORD

Male

Male

Age 45

Age 45

Occupation

Occupation

Married

Married

Dr. George W. H. H.

Witness

11142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowleys Quarters				c. LENGTH OF STAY IN 1b lyr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 479 A Burke Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clyde Middle H. Last Mould				4. DATE OF DEATH Month Oct Day 1 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1905	9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kingston, New York	
13. FATHER'S NAME Joseph E. Mould				14. MOTHER'S MAIDEN NAME Emma Haver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes War 11				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr Hook 479A Burke Road				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary embolism 450-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic vascular disease DUE TO (c) gangrene right leg INTERVAL BETWEEN ONSET AND DEATH immediate 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 30, 1960 , to Oct 1, 1960 , that I last saw the deceased alive on Sept 30, 1960 , and that death occurred at 9 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2108 CREMS RD Balto Md DATE SIGNED 10/1/60 ACTUAL SIGNATURE Louis Semenov M.D. PHYSICIAN'S NAME (Type) LOUIS SEMENOV							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 5, 1960	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Frederick Rd. Balto Md			
23. FUNERAL DIRECTOR'S SIGNATURE LEO G. COOK				24a. REC'D BY REGISTRAR DATE OCT 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. GOVERNMENT PRINTING OFFICE: 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
11143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11124																			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 54 Essex (21)														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 415 Edgewater Apts.					d. STREET ADDRESS 415 Middle River Edgewater Apts. e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO														
3. NAME OF DECEASED (Type or print) DOTTIE ANN MUIR					4. DATE OF DEATH October 3, 19 60														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/15/60		9. AGE (In years last birthday) yrs. 17 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY ---					11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE CITY									
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME James Muir					14. MOTHER'S MAIDEN NAME Lois Ann Pressman									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT James Muir Address Same									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)					20g. (County)					20h. (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																			
DATE SIGNED 10/3/60																			
ACTUAL SIGNATURE Russell S. Fisher M.D.																			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.																			
Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal					22b. DATE THEREOF 10/4/60					22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery									
22d. LOCATION (City, town, or country) (State) Frostburg, Maryland																			
23. FUNERAL DIRECTOR James Bruzdinski ADDRESS 1407 Eastern Ave.										24a. REC'D BY REGISTRAR DATE OCT 5 '60					24b. REGISTRAR'S SIGNATURE Arthur L. Kline				

11-11-11

11-11-11

11-11-11

MEDICAL EXAMINATION CERTIFICATE OF DEATH

STATE OF NEW YORK
COUNTY OF [illegible]
I, [illegible], a duly qualified and licensed physician, do hereby certify that on the [illegible] day of [illegible] A.D. 19[illegible] at [illegible] in the County of [illegible] State of New York, I examined the body of [illegible] deceased, and found that the cause of death was [illegible] and that the death was due to [illegible] and not to any other cause.

Witness my hand and the seal of my office this [illegible] day of [illegible] A.D. 19[illegible].

[illegible signature]

[illegible stamp]

CERTIFICATE OF DEATH

11125
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN lb LIFE		d. STREET ADDRESS 18102 EASTERN AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8102 EASTERN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MELVIN N. MYERS (MEYERS)		4. DATE OF DEATH Month OCTOBER Day 23 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 31, 1910
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.	11. IF UNDER 24 HRS. Months 50 Days 50 Hours 50 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIPPER & CAULKER		10b. KIND OF BUSINESS OR INDUSTRY BETH STEEL CO	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES MYERS		14. MOTHER'S MAIDEN NAME EMMA SACHS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WORLD # 2 213 09 3141	
17. INFORMANT MRS LAURA W. MYERS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas and liver DUE TO (b) 157x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 157x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-30 , 19 60 , to 10-23 , 19 60 , that I last saw the deceased alive on 10-22 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-24-60			
ACTUAL SIGNATURE John J. Gould		M.D. 147926-1	
PHYSICIAN'S NAME (Type) JOHN J. GOULD		Baltimore 24	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/27/60	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.		24a. REC'D BY REGISTRAR OCT 26 60	
24b. REGISTRAR'S SIGNATURE Charles E. Haines			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

11158

RECEIVED BY THE DEPARTMENT OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11145

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11126

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt Carmel Rd</u>				d. STREET ADDRESS <u>Mt Carmel Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>B</u> Last <u>Nash</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 1894</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Caggy Ensor</u>				14. MOTHER'S MAIDEN NAME <u>Martha Benson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Walter Mays Parkton Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>60 hours</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 5</u> 19 <u>60</u> , to <u>Oct 7</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct 6</u> 19 <u>60</u> , and that death occurred at <u>2AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-7-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>Hampstead Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-9-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Methodist</u>		23d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson 4, Md.</u>				ADDRESS <u>—</u>		25a. REC'D BY REGISTRAR <u>OCT 10 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1113

CERTIFICATE OF DEATH

1113

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death" are faintly visible.]

Townsend, Mass.

Attest: Wm. Townsend, Registrar

Witness: J. B. Townsend, Justice

Recorded: J. B. Townsend, Justice, Townsend, Mass.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11146

11127

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.			c. LENGTH OF STAY IN 1b 31 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (19)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 12902 Ritchie Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LEWIS Middle L. Last (Notaronicola) NOTARO				4. DATE OF DEATH Month October Day 19 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1921		9. AGE (In years last birthday) yrs. 39	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Setter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Pietro Notaro				14. MOTHER'S MAIDEN NAME Catherine Aiello			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-14-8491		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONEAL ADHESIONS (POST OPERATIVE) 577X XXXX ACUTE PEPTIC ULCER, STOMACH GASTROJEJUNOSTOMY, STENOTIC (b) XXXX PLEURAL EFFUSION, LEFT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) EMACIATION, MARKED							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operations: EnterO-enterostomy. Old. 2. Ileostomy October, 1960							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 28, 1960 , to Oct. 19, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 19, 1960 , and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Fredrick S. Donaldson</i>				22b. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-22-1960		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Duda, 7922 Wise Ave., Baltimore, Md.				25a. REC'D BY REGISTRAR DATE OCT 24 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

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ADMINISTRATIVE INFORMATION

DATE

TIME

PLACE

A. A. A.

REMARKS

DESCRIPTION

STATUS

LOCATION

REMARKS

ADMINISTRATIVE INFORMATION

DATE

TIME

PLACE

REMARKS

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DESCRIPTION

ADMINISTRATIVE INFORMATION

1118

1118

ADMINISTRATIVE INFORMATION

DESCRIPTION

STATUS

ADMINISTRATIVE INFORMATION

11147

CERTIFICATE OF DEATH

11128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home House in the Pines Nursing</i>		d. STREET ADDRESS <i>2402 Southern Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Addie</i> Middle <i>B.</i> Last <i>O'Donnell</i>		4. DATE OF DEATH Month <i>10-</i> Day <i>10</i> Year <i>19 60</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-3-1883</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Parks</i>		14. MOTHER'S MAIDEN NAME <i>Jenny (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Gloria M. Grikit</i>		Address <i>1325 Stevens Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebro-Vascular Accident.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/29, 1959</i> , to <i>10/10, 1960</i> , that I last saw the deceased alive on <i>10/10, 1960</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. N. Frederick</i>		M.D. <i>1305 Francis Ave</i>	
PHYSICIAN'S NAME (Type) <i>J. N. Frederick M.D.</i>		<i>Balto, 27, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>10-13-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR <i>Oct 13 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD
11117

11117

CERTIFICATE OF DEATH

11118

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White	
DATE OF DEATH 11-11-1917		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Retired		EDUCATION High School	
BIRTH DATE 11-11-1852		BIRTH PLACE Maryland		MARRIAGE DATE 11-11-1875		MARRIAGE PLACE Maryland	
FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker	
DECEASED'S RESIDENCE 11117		DECEASED'S OCCUPATION Retired		DECEASED'S EDUCATION High School		DECEASED'S RELIGION Roman Catholic	
DECEASED'S MARITAL STATUS Married		DECEASED'S SOCIAL STATUS Middle Class		DECEASED'S ETHNIC ORIGIN Caucasian		DECEASED'S ANCESTRY English, Irish	
DECEASED'S BIRTH DATE 11-11-1852		DECEASED'S BIRTH PLACE Maryland		DECEASED'S MARRIAGE DATE 11-11-1875		DECEASED'S MARRIAGE PLACE Maryland	
DECEASED'S FATHER'S NAME John Harris		DECEASED'S MOTHER'S NAME Mary Harris		DECEASED'S FATHER'S OCCUPATION Farmer		DECEASED'S MOTHER'S OCCUPATION Homemaker	
DECEASED'S RESIDENCE 11117		DECEASED'S OCCUPATION Retired		DECEASED'S EDUCATION High School		DECEASED'S RELIGION Roman Catholic	
DECEASED'S MARITAL STATUS Married		DECEASED'S SOCIAL STATUS Middle Class		DECEASED'S ETHNIC ORIGIN Caucasian		DECEASED'S ANCESTRY English, Irish	
DECEASED'S BIRTH DATE 11-11-1852		DECEASED'S BIRTH PLACE Maryland		DECEASED'S MARRIAGE DATE 11-11-1875		DECEASED'S MARRIAGE PLACE Maryland	
DECEASED'S FATHER'S NAME John Harris		DECEASED'S MOTHER'S NAME Mary Harris		DECEASED'S FATHER'S OCCUPATION Farmer		DECEASED'S MOTHER'S OCCUPATION Homemaker	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11148

11129

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7yr7mth19dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Margaret Last O'Donnell				4. DATE OF DEATH Month October Day 13 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1889		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) packer				10b. KIND OF BUSINESS OR INDUSTRY The Parker Metal		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME John Bernard O'Donnell			
14. MOTHER'S MAIDEN NAME Marie McGreevey				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown			
16. SOCIAL SECURITY NO. 212-03-9917				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppurative Meningitis DUE TO Gangrenous decubital ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3402 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 14, 1960 to 10.13.1960 , that (I) (we) lost the deceased alive on 10.13.1960 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				22b. DATE SIGNED 10/13/60		22c. PHYSICIAN'S NAME (Type) STELLA WACHSLER	
22d. ADDRESS SPRING GROVE STATE HOSPITAL				22e. ADDRESS Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-1960		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G. HOWARD STRONG BALTIMORE, MD.				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kinner	

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MEDICAL CERTIFICATION

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ORIGINAL OF DEATH

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the funeral director, the attending physician and completely filled in. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11149

11130

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore County				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 6 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE City				3V 01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital								d. STREET ADDRESS 1915 W. LOMBARD STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH				First JAMES				Middle O'HALLORAN				Last			
4. DATE OF DEATH				Month 10				Day 26				Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 8, 1912		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY RAILWAY EXPRESS				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOSEPH JAMES O'HALLORAN				14. MOTHER'S MAIDEN NAME KATHERINE Mc DONALD											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 215-05-8992				17. INFORMANT Hospital Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-20 1960 to 10-26 1960, that (I) (we) last saw the deceased alive on Oct 26 1960, and that death occurred at 9:25 A.M. from the causes and on the date stated above.															
22a. SIGNATURE Wm. Newomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10/26/60							
22c. PHYSICIAN'S NAME (Type) Wm. Newomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/29/60				23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.				23d. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd.			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan				ADDRESS 95 Collins St.				25a. REC'D BY REGISTRAR DATE OCT 27 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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11150

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11131

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 2 mo. 2 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Tr. School		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) First Rosetta Middle Linda Last Parker		4. DATE OF DEATH Month 10 Day 31 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		9. AGE (In years last birthday) 42 yrs. IF UNDER 1 YEAR: Months 42 Days 42 Hours 42 Min. IF UNDER 24 HRS. Months 42 Days 42 Hours 42 Min.	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Leon Parker		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Josephine Alice Downs, Lothian, Md.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -----	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Rosewood Records Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition; Decubitus ulcers of the scalp, left; diffuse bronchopneumonia bilaterally. DUE TO 224X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cranio pharyngioma with cyst producing obstructive hydrocephalus, marked and systematic epilepsy. DUE TO 1 1/2 yrs. (c) -----			INTERVAL BETWEEN ONSET AND DEATH 6 months.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes insipidus not verified - 1 1/2 yrs.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 8/29 19 60 to 10/31 19 60 , that (I) (we) last saw the deceased alive on 10/31 1960, and that death occurred at 6:50 p.m. on the causes and on the date stated above.			
22a. SIGNATURE Harry G. Butler, M.D.		22b. DATE SIGNED 11/3/60	
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		22d. ADDRESS Rosewood Lane, Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6/9/60	23b. DATE THEREOF 6/9/60	23c. NAME OF CEMETERY OR CREMATORY -----	23d. LOCATION (City, town, or county) (State) Lothian Md
24. FUNERAL DIRECTOR'S SIGNATURE John B. Johnson		25a. REC'D BY REGISTRAR NOV 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REGISTRAR'S SIGNATURE -----	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

11132

Reg. Dist. No.

11037

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8025 NORRIS LANE</u>		e. STREET ADDRESS <u>18025 NORRIS LANE</u>	
3. NAME OF DECEASED (Type or print) <u>Otelia</u> First <u>Payline</u> Middle <u>PATTERSON</u> Last		4. DATE OF DEATH <u>October 1</u> Month <u>1960</u> Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 6, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR <u>10</u> Months <u>25</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Appomattox, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Willie D. Ferguson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Goodridge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Earl Patterson</u> Address <u>8025 NORRIS LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> DUE TO <u>Myemia</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Pneumonia</u> DUE TO (c) <u>Carcinoma of Colon</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>5 days</u> <u>8 days</u> <u>24 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUGUST 25, 1958</u> to <u>OCTOBER 1, 1960</u> that I last saw the deceased alive on <u>OCTOBER 1, 1960</u> , and that death occurred at <u>4:10</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u>		DATE SIGNED <u>10/1/60</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-4-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11193

CERTIFICATE OF DEATH

11193

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Death		October 28, 1918	
Place of Death		Home	
Cause of Death		Pneumonia	
Occupation		Farmer	
Residence		123 Main St, Baltimore, Md.	
Burial Place		Greenwood Cemetery	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		November 5, 1918	
Registrar's Office		Baltimore, Md.	

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines		d. STREET ADDRESS 3404 Dolfield Avenue	
3. NAME OF DECEASED (Type or print) First BESSIE Middle PAUL Last PAUL		4. DATE OF DEATH Month October Day 12 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Goldman		14. MOTHER'S MAIDEN NAME Rachel ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. Felix Paul- 3914 Fallstaff Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 193-9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Ca of Lung DUE TO 62m.s. (c) Ca of Brain (RT. side) 732.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20- 1959 , to 10-12- 1960 , that I last saw the deceased alive on 10-20- 1960 , and that death occurred at 2 P M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE William K. Gallagher M.D. 6209 Frederick Ave.		10-12-60	
PHYSICIAN'S NAME (Type) William K. Gallagher		Baltimore - 28	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 16/60	22c. NAME OF CEMETERY OR CREMATORY Shaarei Tfiloh	22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Road		24a. REC'D BY REGISTRAR OCT 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krand			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G273 10-14-60 et

CERTIFICATE OF DEATH

11134

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>SV 01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in lines</u>		d. STREET ADDRESS <u>3118 Oakfield Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>-</u> Last <u>Perkal</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>6</u> - Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Peretz</u>	
14. MOTHER'S MAIDEN NAME <u>Hinda</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Moses Davis - 7309 Campfield Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio Vascular Disease</u> 422.1 DUE TO <u>none</u> (b) <u>none</u> DUE TO <u>none</u> (c) <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 30</u> , 19 <u>57</u> , to <u>October 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October 6</u> , 19 <u>60</u> , and that death occurred at <u>7 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manuel Levin</u>		ADDRESS (Street, city or town, state) <u>4818 Reisterstown Rd</u> DATE SIGNED <u>10/8/60</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, M.D.</u>		<u>Baltimore - 15 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-9-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Tzefon</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u>		ADDRESS <u>2100 Eutan Place</u>	
24a. REC'D BY REGISTRAR <u>OCT 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

11153

CERTIFICATE OF DEATH

Reg. Dist. No. 11135

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women & Men's Home</u>		d. STREET ADDRESS <u>504 Delaware Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Florence</u> First Middle Last		4. DATE OF DEATH <u>October 30</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7- 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Towson, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Phipps</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Hipe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Daisy E. Hamilton, 615 Chestnut Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bowel</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>October 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October 30</u> , 19 <u>60</u> , and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland Edward Day</u>		ADDRESS (Street, city or town, state) <u>M.D. 4-9-33rd St Balt 18 md</u>	
PHYSICIAN'S NAME (Type) <u>William Cook, Inc., 1217 St. Paul Street</u>		DATE <u>NOV 1 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-2-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Govans Presbyterian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Govans, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>NOV 1 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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11154
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11136

1. PLACE OF DEATH a. COUNTY baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 d. STREET ADDRESS 6806 Fait Avenue 3 V0 14 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK F. PIECHOCKI		4. DATE OF DEATH Month Day Year October 4 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1896
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Steel Company	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Martin Piechocki		14. MOTHER'S MAIDEN NAME Mary Novak	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 213-09-2502	
17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 BRONCHOGENIC CARCINOMA, LEFT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATELECTASIS, LEFT LUNG (c) EMPHYSEMA, BOTH LUNGS (d) METASTATIC CARCINOMA, OMENTUM, LIVER, LEFT 4TH RIB		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED. EMACIATION.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (Caunty) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 14 8-45 to Oct. 4 1960, that (I) (we) last saw the deceased alive on Oct. 4 1960, and that death occurred at 1 M, from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22b. DATE SIGNED 10/4/60 22d. ADDRESS VAH, BALTIMORE 18, MD. - FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-8-60	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Walter Dabrowski, 1001-A Dundalk Ave., Balto. 22, Md.		25a. REC'D BY REGISTRAR OCT 7 '60 25b. REGISTRAR'S SIGNATURE Curtis S. Kraus	

CERTIFICATE OF DEATH

11114

11114

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11137**

11155

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 61 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 517 Overbrook Road				d. STREET ADDRESS 1 517 Overbrook Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle J. Last PRICE				4. DATE OF DEATH Month Oct. Day 26 , Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY Wiping Cloth Maker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Price				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-8971		17. INFORMANT Address Myrtle M. Price - 517 Overbrook Rd, 12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO 2 spot (c) _____						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/27/60	
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/60		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.				ADDRESS 1050 York Rd. Towson		24a. REC'D BY REGISTRAR Oct 31 60	
				24b. REGISTRAR'S SIGNATURE Charles F. O'Donnell			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IN ARIZONA STATE DEPARTMENT OF HEALTH - BIRMINGHAM

11156

CERTIFICATE OF DEATH

Reg. Dist. No. 11138

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN ARM. MD.		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 31, GLEN ARM.		d. STREET ADDRESS Box 31, GLEN ARM.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle M. Last PRIGEL		4. DATE OF DEATH Month OCT Day 5 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 21, 1873
9. AGE (In years last birthday) 87. yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMER	
11. BIRTHPLACE (State or foreign country) MARYLAND.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME MATTHEW PRIGEL		14. MOTHER'S MAIDEN NAME UNKNOWN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 120-34-6179	
INFORMANT EMMA PRIGEL		Address Box 31, GLEN ARM P.O.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerosis DUE TO (c) Abless Kidney		INTERVAL BETWEEN ONSET AND DEATH 2 weeks years unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 6 , 19 60 to Oct 5 , 19 60 that I last saw the deceased alive on Oct 6 , 19 60 , and that death occurred at 4 P. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore DATE SIGNED Walter M. Hammitt	
ACTUAL SIGNATURE Walter M. Hammitt		PHYSICIAN'S NAME (Type) Walter M. Hammitt	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY CHURCH OF THE BRETHREN CEM.		22d. LOCATION (City, town, or county) (State) LONG GREEN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Jessie H. Funeral Home		ADDRESS 7401 Belair Rd. #6.	
24a. REC'D BY REGISTRAR OCT 10 '60		24b. REGISTRAR'S SIGNATURE John S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18. DECEMBER 1974

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11139**

11157

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loch Raven</u>			c. LENGTH OF STAY IN 1b <u>Loch Raven</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cromwell Bridge Rd.</u>				e. STREET ADDRESS <u>Cromwell Bridge Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William T. Prime</u>				4. DATE OF DEATH Month Day Year <u>October 31, 19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1907</u>		9. AGE (In years last birthday) <u>53</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Prime</u>			
14. MOTHER'S MAIDEN NAME <u>Sally O'Donell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			
16. SOCIAL SECURITY NO. <u>W. W. # 2 214-01-1659</u>		17. INFORMANT Address <u>Mrs. Stella Prime Cromwell Bridge Rd. 34</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Oct 31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>60</u> , and that death occurred at <u>7:05 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor Francis King</u> M.D.		ADDRESS (Street, city or town, state) <u>1103 E. Joppa Rd.</u>		DATE SIGNED <u>10/31/60</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-2-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassaker Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>			
24a. REC'D BY REGISTRAR DATE <u>NOV 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11130

CERTIFICATE OF DEATH

11130

Blank certificate form with faint horizontal lines and a large rectangular box on the right side.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11158

CERTIFICATE OF DEATH

11140

 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kingsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Lane</u>				d. STREET ADDRESS <u>Cedar Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Pumphrey</u> First Middle Last				4. DATE OF DEATH <u>Oct. 7 1960</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1879</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co., Md.</u>			
13. FATHER'S NAME <u>Steven T. Rodgers</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Redmiles</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXXX-XX-XXXX</u>		17. INFORMANT Address <u>XXXX-XX-XXXX</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> <u>Myocardial Insufficiency</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Feb. 1956</u> to <u>Oct. 1960</u> , that I last saw the deceased alive on <u>Oct. 7 1960</u> , and that death occurred at <u>945</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>William W. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u>		DATE SIGNED <u>10-7-60</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11th Oct 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>		24a. REC'D BY REGISTRAR ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		DATE <u>OCT 10 '60</u>		24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.
100% COTTON
WASHABLE
DO NOT BLEACH
DO NOT DRY CLEAN
DO NOT IRON
DO NOT TUMBLE DRY
DO NOT USE HEAT
DO NOT USE STEAM
DO NOT USE DRY CLEANING
DO NOT USE PRESSURE
DO NOT USE SOAP
DO NOT USE DETERGENT
DO NOT USE BLEACH
DO NOT USE CHLORINE
DO NOT USE ACID
DO NOT USE ALKALI
DO NOT USE OIL
DO NOT USE GREASE
DO NOT USE LUBRICANT
DO NOT USE POLISH
DO NOT USE WAX
DO NOT USE VARNISH
DO NOT USE GLUE
DO NOT USE STITCHES
DO NOT USE SEWING
DO NOT USE NEEDLE
DO NOT USE SCISSORS
DO NOT USE CUTTERS
DO NOT USE SHARP OBJECTS
DO NOT USE FIRE
DO NOT USE FLAME
DO NOT USE HEAT
DO NOT USE SUNLIGHT
DO NOT USE MOISTURE
DO NOT USE WATER
DO NOT USE SOAP
DO NOT USE DETERGENT
DO NOT USE BLEACH
DO NOT USE CHLORINE
DO NOT USE ACID
DO NOT USE ALKALI
DO NOT USE OIL
DO NOT USE GREASE
DO NOT USE LUBRICANT
DO NOT USE POLISH
DO NOT USE WAX
DO NOT USE VARNISH
DO NOT USE GLUE
DO NOT USE STITCHES
DO NOT USE SEWING
DO NOT USE NEEDLE
DO NOT USE SCISSORS
DO NOT USE CUTTERS
DO NOT USE SHARP OBJECTS
DO NOT USE FIRE
DO NOT USE FLAME
DO NOT USE HEAT
DO NOT USE SUNLIGHT
DO NOT USE MOISTURE
DO NOT USE WATER

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

11152

1. NAME OF DECEASED <i>John Doe</i>	
2. SEX <i>Male</i>	
3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15, 1925</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>	
6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>	
8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
11. SIGNATURE OF WITNESS <i>John Doe</i>	
12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF FUNERAL HOME <i>Funeral Home</i>	
14. SIGNATURE OF COUNTY CLERK <i>County Clerk</i>	
15. SIGNATURE OF STATE CLERK <i>State Clerk</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111151

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11141

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1 Box 389 Kingsville, Md.</u>		d. STREET ADDRESS <u>Rt. 1 Box 389</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>A.</u> Last <u>Quick</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1865</u>
9. AGE (In years lost birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Quick</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Seifert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harry G. Quick</u>		Address <u>Rt. 1 Box 389 Kingsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 13</u> <u>1960</u> to <u>Oct 16</u> <u>1960</u> , that (I) (we) lost saw the deceased alive on <u>Oct 16</u> <u>1960</u> , and that death occurred at <u>12:15 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Fred O. Hodous</u>		22b. DATE SIGNED <u>10-17-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Fred O. Hodous</u>		22d. ADDRESS <u>Edgewood Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 19, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		23d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 '60</u>	
ADDRESS <u>7401 Belair Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

11133

CERTIFICATE OF DEATH

11133

(M)

(1)

(C)

(C)

(C)

(C)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND <u>Sumit Nursing Home</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md</u> c. LENGTH OF STAY IN 1b <u>3 Weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore City</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>I907 Griffiss Ave</u> d. STREET ADDRESS <u>3V01-4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Patrick F. Reedy</u> Middle Last				4. DATE OF DEATH Month <u>10-12</u> Day <u>1960</u> Year											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-1871 ?</u>		9. AGE (In years last birthday) <u>89 ?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Brass Machine CO</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Michael Reedy</u>						14. MOTHER'S MAIDEN NAME <u>-----</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-05-1253</u>				17. INFORMANT <u>Bernard J Mory</u> Address <u>200I Harman Ave Balto 30 Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO <u>450.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Obliterans</u> DUE TO <u>with Developing Gangrene Rt Foot</u> (c) <u>Amputation Mid thigh left old</u>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputation Mid thigh left old</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>10/12/60</u>		(County) <u>Balto Co</u>		(State) <u>Md</u>			
21. I certify that I attended the deceased from <u>9/22/60</u> 19 to <u>10/12/60</u> 19 that I last saw the deceased alive on <u>10/14/60</u> 19 and that death occurred at <u>320P</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28 Md</u> DATE SIGNED <u>10/13/60</u>															
ACTUAL SIGNATURE <u>W E McGraw</u> M.D.				PHYSICIAN'S NAME (Type) <u>W E McGraw</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem</u>				22d. LOCATION (City, town, or county) <u>Balto Co Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson 2359 Wash Balto Md</u>						24a. REC'D BY REGISTRAR DATE <u>OCT 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11112

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

11110

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF CLERK		SIGNATURE OF RECORDS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF CLERK		SIGNATURE OF RECORDS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11161

CERTIFICATE OF DEATH

11143

Reg. Dist. No. 3898

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 Winters Lane				d. STREET ADDRESS 44 Winters Lane			
3. NAME OF DECEASED (Type or print) First ASBURY Middle C. Last RIDEOUT				4. DATE OF DEATH Month Oct. Day 27 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1902	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Rideout				14. MOTHER'S MAIDEN NAME Lillian Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Violet Rideout Address 44 Winters Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Six years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 11-17-1954 , to 10-27-1960 , that I last saw the deceased alive on 10-27-1960 , and that death occurred at 4:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1029 N. Stricker DATE SIGNED St 10-28-60							
ACTUAL SIGNATURE Frank A. Saunders M.D.		PHYSICIAN'S NAME (Type) FRANK A. SAUNDERS MD Baltimore 17 Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-30-60	22c. NAME OF CEMETERY OR CREMATORY Western Star		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Frances A. Hemsley (Mrs) Frances A. Hemsley				24a. REC'D BY REGISTRAR DATE NOV 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11162

CERTIFICATE OF DEATH

11144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium, Balto. County</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium, Baltimore, County, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1841 Locust Ridge Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH HOPE ROBINSON</u>		4. DATE OF DEATH Month Day Year <u>Oct. 29, 1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1893</u>
9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abel Durham</u>		14. MOTHER'S MAIDEN NAME <u>Ella Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-20-2790</u>	
17. INFORMANT <u>Mrs. Virginia R. Hunt</u>		Address <u>Timonium, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with generalized metastasis</u> DUE TO (c) <u>1-yr.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1, 1960</u> , to <u>Oct 29, 1960</u> , that I last saw the deceased alive on <u>Oct 28, 1960</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George T. Towson, M.D.</u> <u>Luther S. Kline</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 1, '60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.</u>		ADDRESS <u>1050 York Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11145

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harward	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 15 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		513 Baltimore Street	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle — Last ROHOL		4. DATE OF DEATH Month OCTOBER Day 13 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28, 1917
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckers Helper		10b. KIND OF BUSINESS OR INDUSTRY Distillery	
11. BIRTHPLACE (State or foreign country) Gates, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Rohol		14. MOTHER'S MAIDEN NAME Anna (Last Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT CLIN. RECORDS. VAH, BALTO. MD. FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 13, 1960 , to October 13, 1960 , that (I) (we) lost the deceased alive on October 13, 1960 , and that death occurred on October 13, 1960 from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Koukoulas		22b. DATE SIGNED 10/13/60	
22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS, M.D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/17/60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE DONALDSON FUNERAL HOME, TALBOTT STREET, LAUREL, MD		25a. REC'D BY REGISTRAR OCT 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna		25c. DATE OCT 19 '60	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11164

11146

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Frank Last Sauers				4. DATE OF DEATH Month 10 Day 1 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11-7-1901	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 8 Hours 1 Min.		IF UNDER 24 HRS. Months 5 Days 8 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER				10b. KIND OF BUSINESS OR INDUSTRY JOHN HOPKINS SCHOOL			
11. BIRTHPLACE (State or foreign country) Maryland Balto.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William F. Sauers				14. MOTHER'S MAIDEN NAME Olive Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) X				16. SOCIAL SECURITY NO. ✓			
17. INFORMANT Hospital Records, Mt. Wilson State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis and Empyema. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that X (this hospital) attended the deceased from 8-3-1960 to 10-1-1960 that X (we) last saw the deceased alive on 10-1-1960 , and that death occurred at 1038 M, from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 10-1-60			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		10/3/60		London Park Cemetery		3801 Redneck Ave	
24. FUNERAL DIRECTOR'S SIGNATURE J. Bowman				25a. REC'D BY REGISTRAR DATE OCT 4 '60			
ADDRESS 901 Hollins St				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

111165

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11147

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3700 Villa Nova Ave.				d. STREET ADDRESS 3309 Dorchester Rd.			
3. NAME OF DECEASED (Type or print) First DAVID Middle SAVADOW Last SAVADOW				4. DATE OF DEATH Month October Day 13 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1886	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manuf		10b. KIND OF BUSINESS OR INDUSTRY Barfel		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Victor Savadow				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-34-8563		17. INFORMANT Mrs. Muriel S. Schleider Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) MYOCARDIAL INFARCTION DUE TO A.S.C.U.D. (c) _____						INTERVAL BETWEEN ONSET AND DEATH MINUTE 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 8 19 60 to Oct 13 19 60 , that (I) (we) last saw the deceased alive on Oct 12 19 60 , and that death occurred at 1 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Joseph Shear MD				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) JOSEPH SHEAR MD	
22d. ADDRESS 4413 1/2 PARK HEIGHT AVE BAL 15				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/60		23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh Cong.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE OL LEVINSON & BROS INC.				25a. REGISTRAR'S SIGNATURE Arthur S. Kruza		25b. REGISTRAR'S SIGNATURE DATE OCT 19 '60	

OL LEVINSON & BROS INC, 6010 Reisterstown Rd.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11166

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11148

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 16 Box 508</u>				d. STREET ADDRESS <u>Rt. 16 Box 508</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Sawyer</u> Last <u>Sawyer</u>				4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min. <u>60</u>		IF UNDER 24 HRS. Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			
11. BIRTHPLACE (State or foreign country) <u>England</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Sawyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT Address <u>Mrs. Martha J. Sawyer Rt. 16 Box 508 (20)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROSIS</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 MO.</u> <u>8 YRS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 28</u> 19 <u>57</u> to <u>OCT 18</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>OCT 13</u> 19 <u>60</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Miceli</u> M.D.				22b. DATE SIGNED <u>10/19/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>				22d. ADDRESS <u>108 S. TAYLOR AVE BALTO 21 MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct. 21, 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u>				23d. LOCATION (City, town, or county) (State) <u>Chase, Balto. Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cassidy Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>			
25a. REC'D BY REGISTRAR <u>OCT 20 '60</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraw</u>			

1176

EXHIBIT OF DEATH

1176



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11167

CERTIFICATE OF DEATH

11149

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2Yrs.1Mo.20Das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital		d. STREET ADDRESS 1530 - 30th Street, N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First May Middle Somerville Last Schell		4. DATE OF DEATH Month October Day 31 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1865
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months 95 Days 31 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Canada	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Somerville		14. MOTHER'S MAIDEN NAME Elizabeth McKinnon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Chronic Brain Syndrome; Senile Brain Disease		INTERVAL BETWEEN ONSET AND DEATH 4 da 6 yr - 7 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome; Senile Brain Disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 11 19 58 to Oct 31 19 60 , that (I) (we) last saw the deceased alive on Oct 29 19 60 and that death occurred at 5:30 P from the causes and on the date stated above.			
22a. SIGNATURE J.W. Elgin		22b. DATE SIGNED November 1, 1960	
22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		22d. ADDRESS The Sheppard and Enoch Pratt Hospital Towson 4, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11/2/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph F. BIRCH'S SONS		25a. REC'D BY REGISTRAR NOV 3 '60	
ADDRESS 3034 M St. N.W., D. C.		25b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

11110

CERTIFICATE OF DEATH

11110

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CERTIFICATE OF DEATH

Reg. Dist. No.

11168

11150

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>533 Dale Avenue</i>		d. STREET ADDRESS <i>533 Dale Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mrs.</i> Middle <i>Mary</i> Last <i>Anna</i> Schlicht		4. DATE OF DEATH Month <i>October</i> Day <i>6th</i> Year <i>19 60</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 23, 1893</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Mossberger</i>		14. MOTHER'S MAIDEN NAME <i>Eva ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <i>Mr. Joseph M. Schlicht 533 Dale Ave #6</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> <i>153.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of large bowels</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 ms</i> <i>18 ms</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-5</i> , 19 <i>54</i> , to <i>10-4</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>10-4</i> , 19 <i>60</i> , and that death occurred at <i>4:10</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Santi Amoroso</i>		ADDRESS (Street, city or town, state) <i>6801 Belair Rd Baltimore 6 Md</i>	
PHYSICIAN'S NAME (Type) <i>Leonard J. Ruck</i>		DATE SIGNED <i>10-6-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/10/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 7 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Finner</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

11169

CERTIFICATE OF DEATH

11151
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Linden Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Helen Middle Gertrude Last Seibold		4. DATE OF DEATH Month Oct Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1880
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13. FATHER'S NAME Thomas Fairley		14. MOTHER'S MAIDEN NAME Rose Gettier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-09-967	
17. INFORMANT Mrs. Mary Louise Feustle		Address Pikesville 8, Md. 11 Linden Terrace	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Several yrs (c)		INTERVAL BETWEEN ONSET AND DEATH Several yrs
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **June**, 19**60**, to **24 Oct**, 19**60**, that I last saw the deceased alive on **21 Oct**, 19**60**, and that death occurred at **10** M, from the causes and on the date stated above.

ACTUAL SIGNATURE Paul Royse	M.D. 1403 Foley Lane	DATE SIGNED 10/26/60
PHYSICIAN'S NAME (Type) PAUL H. Royse, M.D. Pikesville 8, Md.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 27, 1960	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville 8, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell	24a. REC'D BY REGISTRAR DATE OCT 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thoms
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

103 MIAIC311110

11181

CERTIFICATE OF DEATH

11151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film G273 10-26-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4419 Block On Wilkins Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward Gray</u> Middle <u>Sensibaugh</u> Last <u>Sensibaugh</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired State Employee State of Md</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George W. Sensibaugh</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Potter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>O. Howard Sensibaugh</u>		Address <u>711 Hammond Ferry Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio sclerotic cardiovascular disease</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct. 22. 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubbard Fur. Home</u>		ADDRESS <u>Baltimore, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11021

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		RACE _____	
STREET ADDRESS _____		CITY _____	
STATE _____		ZIP CODE _____	
DECEASED AT HOME <input type="checkbox"/> Yes <input type="checkbox"/> No		PLACE OF DEATH _____	
TIME OF DEATH _____		DATE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF WITNESS _____	
PRINTED NAME OF MEDICAL EXAMINER _____		PRINTED NAME OF WITNESS _____	
TITLE OF MEDICAL EXAMINER _____		TITLE OF WITNESS _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF NEXT OF KIN _____	
PRINTED NAME OF DECEASED _____		PRINTED NAME OF NEXT OF KIN _____	
ADDRESS OF DECEASED _____		ADDRESS OF NEXT OF KIN _____	
CITY OF DECEASED _____		CITY OF NEXT OF KIN _____	
STATE OF DECEASED _____		STATE OF NEXT OF KIN _____	
ZIP CODE OF DECEASED _____		ZIP CODE OF NEXT OF KIN _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11153

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 8 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 2004 EDGEWOOD ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAS H SHAW		4. DATE OF DEATH Month Day Year OCT 26 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-1867
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BEN HOLROYD		14. MOTHER'S MAIDEN NAME ELIZABETH JACKSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr. Address Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO CARDIO ARTERIO SCALORTIC VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) 8 YEARS (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-3 , 19 52 , to 10-26 , 19 60 , that (I) (we) last saw the deceased alive on 10-26 , 19 60 , and that death occurred at 8:40 A M, from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 10/26/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 28, 1960	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. ADDRESS 1217 St. Paul St. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE OCT 27 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

11158

RECEIPT OF DEATH

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may be recorded by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11171

11154

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs</u>		d. STREET ADDRESS <u>2903 Taylor Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2903 Taylor Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Shelley</u>		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1872</u>
9. AGE (in years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>8</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto, Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Anna. Bowen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO <u>Acute myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Diabetes Mellitus; pernicious anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>12 hours</u> <u>30 hours</u>	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; pernicious anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22, 1957</u> to <u>Oct. 6, 1960</u> that I last saw the deceased alive on <u>Oct. 6, 1960</u> , and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.V. Harbold</u>		ADDRESS (Street, city or town, state) <u>4706 Harford Road Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>H.V. HARBOLD M.D.</u>		DATE SIGNED <u>Oct. 7, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 9, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Huns</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

CERTIFICATE OF DEATH

1917

(M)



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point Dispensary</u> DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beth. Steel Co. Dispensary</u>		d. STREET ADDRESS <u>1520 F Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>R</u> Last <u>Sherbert</u>		4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1918</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Sherbert</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Garnand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-5907</u>	
17. INFORMANT <u>Mrs. Ida Sherbert</u>		Address <u>520 F St. 19, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Fracture</u> 902.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause lost. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell 12 ft. landing on his head</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:20</u> a. m. <u>10/22</u> 19 <u>60</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>factory</u>		20f. (City or town) (County) (State) <u>Sparrows Point Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William V. Lovitt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-26-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Blvd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u>		ADDRESS <u>7922 Wise Ave. 22, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11156

11173

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1807 Ruxton Road				d. STREET ADDRESS 1807 Ruxton Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Henry Elmer Singewald				4. DATE OF DEATH Month Day Year October 28 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1888		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank and Trust		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph T. Singewald				14. MOTHER'S MAIDEN NAME Magdalena Dreyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charlotte Singewald		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Myocarditis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 30 min Gradual 11			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1936 to Oct 28 1960 , that (I) (we) last saw the deceased alive on Oct 28 1960 and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE W. H. Woody				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. William H. Woody				22d. ADDRESS 1403 Park Ave			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Nov. 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetary		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons				ADDRESS 1900 Eutaw Place Baltol7		25a. REC'D BY REGISTRAR DATE NOV 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kimmel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. The funeral director, may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11156

CERTIFICATE OF DEATH

11153

DECEASED

LAST KNOWN PLACE

DATE OF BIRTH

DECEASED

DECEASED

DECEASED

Handwritten signature

CHIEF OF POLICE

DECEASED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

4 1
FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
11174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11157																			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cockeysville P.O.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Stevenson														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore-Harrisburg Expressway					d. STREET ADDRESS Hillside Road														
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM FRANKLIN SKIPPER					4. DATE OF DEATH Month Day Year October 8, 1960														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1901		9. AGE (In years last birthday) 59 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardner		10b. KIND OF BUSINESS OR INDUSTRY W.L.KONE Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME Stephen Skipper					14. MOTHER'S MAIDEN NAME Susan Burnham														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None					16. SOCIAL SECURITY NO. 218-09-4140					17. INFORMANT Family Records									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries with fracture of cervical spine 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto														
20c. TIME OF INJURY Month, Day, Year 10/8 1960					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Expressway									
20f. (City or town) Cockeysville, Baltimore Md.					20g. (County) Baltimore					20h. (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Russell S. Fisher					M.D. Russell S. Fisher, M.D.					DATE SIGNED 10/10/60									
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					Address (Street, city, town, or county) Lutherville, Maryland														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Oct. 12, 1960					22c. NAME OF CEMETERY OR CREMATORY Sater's Cemetery									
23. FUNERAL DIRECTOR John Burns					ADDRESS Sons, Towson, Maryland					24a. REC'D BY REGISTRAR OCT 13 '60									
										24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

THE STATE
DEPT. DIST.



1114

1114

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

IN SENATE, JANUARY 1, 1914

REPORT OF THE MEDICAL EXAMINER

ON THE DEATH OF

JOHN J. BROWN

OF THE CITY OF NEW YORK

DECEASED

ON JANUARY 1, 1914

AT NEW YORK CITY

JOHN J. BROWN

DECEASED

ON JANUARY 1, 1914

AT NEW YORK CITY

JOHN J. BROWN

DECEASED

ON JANUARY 1, 1914

AT NEW YORK CITY

JOHN J. BROWN

DECEASED

ON JANUARY 1, 1914

AT NEW YORK CITY

11175

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11158

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 Hrs 10 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1659 N. Milton Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BERTRAM Middle M Last SMITH				4. DATE OF DEATH Month October Day 5 Year 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1910	
9. AGE (In years lost birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Multilift operator				10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S. A.							
13. FATHER'S NAME Joseph Smith				14. MOTHER'S MAIDEN NAME Elma Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 475-07-8629			
17. INFORMANT Clin. Rec., VAH Balto 18, Md Ft Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11:10PM p. m. 5:20AM				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) 11:10PM 5:20AM			
21. I certify that (X) (this hospital) attended the deceased from October 4, 1960 to October 5, 1960 , that (X) (we) lost saw the deceased alive on October 5, 1960 , and that death occurred at 5:20A M, from the causes and on the date stated above.							
22a. SIGNATURE Frederick S Donaldson				22b. DATE SIGNED October 5, 1960			
22c. PHYSICIAN'S NAME (Type) FREDERICK S DONALDSON, MD				22d. ADDRESS VAH Balto 18, Md Ft Howard Div.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Balto Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John C Miller				25a. REC'D BY REGISTRAR 2431 E Oliver St Balto Md			
25b. REGISTRAR'S SIGNATURE Arthur S. Kears				DATE OCT 7 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11158

CERTIFICATE OF DEATH

11158



11158

11158

may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11176

11159

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 162 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle F. Last SMITH				4. DATE OF DEATH Month OCTOBER Day 18 Year 19 60			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 7, 1893	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENER				10b. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE SMITH				14. MOTHER'S MAIDEN NAME MARY WESLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 215-32-0927		17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA AND PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral Hydronephrosis (c) CARCINOMA OF BLADDER, PARTIALLY REMOVED, WITH FISTULA TO THE SKIN ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 3+ DAYS UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial Cystectomy- Operation 6/7/60. Excision of Fistula & Closure of Bladder 9/25/60						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 9, 1960 to October 18, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 18, 1960 , and that death occurred at 5:05 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick S. Donaldson</i>				22b. DATE 10/19/60		22c. PHYSICIAN'S NAME FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD-FT. HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-24-60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Law</i>				25a. REC'D BY REGISTRAR Charles H. Law		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
25c. ADDRESS 802 Madison Ave., Baltimore, Md.				25d. DATE OCT 21 '60			

11150

CERTIFICATE OF DEATH

11150



DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

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PLACE OF BIRTH

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DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

AGE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

AGE

SEX

DATE OF DEATH

DATE OF DEATH

AGE

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

11177
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11160

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparks				c. LENGTH OF STAY IN life life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cedar Grove Road				d. STREET ADDRESS Cedar Grove Road			
3. NAME OF DECEASED (Type or print) First David Middle Henry Last Snow				4. DATE OF DEATH Month October Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) ys. 6 wks. Months 6 Days 0		11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE	
13. FATHER'S NAME David H. Snow				14. MOTHER'S MAIDEN NAME Bette Flanagan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT David H. Snow,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis 525 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/15/60	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove		22d. LOCATION (City, town, or country) (State) Parkton, Md.	
23. FUNERAL DIRECTOR Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR DATE OCT 19 '60		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

2044141XV5

(M)

(1)

From Federal Service, Towns, Md.

10-17-60 Cedar Grove

James A. Petty, M.D.

10-17-60

Town, Md.

10/17/60

X

X

X

Internal medicine

none

David H. Snow,

above

David H. Snow

Essex, Wisconsin

none

Very faint, Baltimore

U.S.A.

Male

White

2-7-60

and

David

Henry

none

October 15

Cedar Grove Road

Cedar Grove Road

Boone

Life

Boone

Baltimore

Harland

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

11178

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2,8,9 Film G273 10-18-60 et

CERTIFICATE OF DEATH

11161
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8101 Parkdale Rd.</i>		e. STREET ADDRESS <i>8101 Parkdale Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle Last <i>Solli</i>		4. DATE OF DEATH Month <i>10</i> Day <i>10</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 18, 1915</i>
9. AGE (In years last birthday) <i>45</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bendix Radio</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Hans Solli</i>		14. MOTHER'S MAIDEN NAME <i>Kristine Moon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Sarah M. Solli</i>	
17. ADDRESS <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Maligant Brain Tumor inoperable</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sept 59</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 59</i> to <i>Oct 10, 60</i> , that I last saw the deceased alive on <i>Sept 30, 1960</i> , and that death occurred at <i>4 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Erwin E. Mayer</i> M.D.		DATE SIGNED <i>The Examiner 17</i>	
PHYSICIAN'S NAME (Type) <i>ERWIN E. MAYER</i>		<i>Baltimore 17</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>10-13-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 13 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

1211



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP A15 (4)
15M 9/59

1
B#
11179
Item 23b, Film G274 11/17/60 1wk
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11162

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 55 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1030 N. Luzerne Avenue (5)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES		Middle R.		Last SPENCER		4. DATE OF DEATH Month October		Day 26		Year 1960	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 16, 1923		9. AGE (In years last birthday) 37		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier				10b. KIND OF BUSINESS OR INDUSTRY U. S. A. Army		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Spencer						14. MOTHER'S MAIDEN NAME Mildred					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 7/20/42-7/15/60		17. INFORMANT CLINICAL RECORDS VAH, Baltimore 18, Md. FORT HOWARD DIVISION					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH WIDESPREAD METASTASES 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) (State)	
21. I certify that 23 (this hospital) attended the deceased from Sept. 14, 1960 to Oct. 26, 1960 , that (he/she) last saw the deceased alive on Oct. 26, 1960 , and that death occurred at A M., from the causes and on the date stated above.											
22a. SIGNATURE Walter J. Pijanowski						22b. DATE 10/26/60			22c. PHYSICIAN'S NAME (Type or print) WALTER J. PIJANOWSKI, M.D.		
22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION						22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/1/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City, town, or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson						25a. REC'D BY REGISTRAR OCT 28 '60			25b. REGISTRAR'S SIGNATURE Arthur L. Hanna		

6011

6111



may be filled by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

111180

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11163

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Granite d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Offutt Road				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite d. STREET ADDRESS Offutt Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mr. George P. Stanfield				4. DATE OF DEATH Month Day Year Oct. 28 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1867	9. AGE (In years lost birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Randallstown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Stanfield				14. MOTHER'S MAIDEN NAME Amelia Beckley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. XXXXXXXXXXXX		17. INFORMANT Address Mr. Edward Stanfield			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart-Failure DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Randallstown, Md.	20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/11/60 to 10/28/60 , that (I) (we) last saw the deceased alive on 10/28/60 , and that death occurred on 10/28/60 from the causes and on the date stated above.							
22a. SIGNATURE Dr. Wm. E. Martin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Wm. E. Martin		22d. ADDRESS Randallstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 31, 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Paran		23d. LOCATION (City, town, or county) (State) Harrionsville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Road		25a. REC'D BY REGISTRAR DATE NOV 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

Loring Byers 8728 Liberty Road
Randallstown, Md.

11/1/40

CERTIFICATE OF DEATH

11/1/40

11/1/40

GREENAVILLE

RECORDS

MADE IN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

111181

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11164

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (22) 53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 113 Balnew Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle J. Last STAPLES				4. DATE OF DEATH Month October Day 27 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1907		9. AGE (In years lost birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Keysville, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dock Staples				14. MOTHER'S MAIDEN NAME Mary Stokes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 083-10-3827		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASIS TO THE BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162.1 (c) 162.1 DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		20i. (City or town)	
21. I certify that (X) (this hospital) attended the deceased from 11 of Oct. 1960 to 27 of Oct. 1960 , that (X) (we) last saw the deceased alive on October 27 1960 , and that death occurred at 12:20 M, from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE 10/27/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.				22e. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.		22f. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-31-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Charles R. Law Mortuary				25a. REC'D BY REGISTRAR Oct 31 '60		25b. REGISTRAR'S SIGNATURE Charles S. Frank	

11101

11181

CERTIFICATE OF DATA

(M)

(1)

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11182

11165

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 28 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School				d. STREET ADDRESS 1100 Cooks Lane			
3. NAME OF DECEASED (Type or print) First Howard Middle William Last Stromberg				4. DATE OF DEATH Month Oct. Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-28-18	
9. AGE (In years last birthday) 42		IF UNDER 1 YEAR Months 4 Days 2		IF UNDER 24 HRS. Hours 4 Min. 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Edward D. Stromberg			
14. MOTHER'S MAIDEN NAME Mary E. Tucker				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none				17. INFORMANT Rosewood St. Tr. School Records Address Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Food est. 1 hr. DUE TO (b) Atelectesis due to Fecal Impaction est. 6 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pneumonitis est. 1 hr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anoxia							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 9		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-7-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct-8, 1960			
22c. NAME OF CEMETERY OR CREMATORY New-Cathedral Cem.				22d. LOCATION (City, town, or country) (State) Balto. Md.			
23. FUNERAL DIRECTOR S. T. Tuman				24a. REC'D BY REGISTRAR ACT 13 '60			
24b. REGISTRAR'S SIGNATURE S. T. Tuman				3512 Field. Ave.			

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

11182

DEPARTMENT OF HEALTH

11182

1

CERTIFICATE OF DEATH

11166
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE AS b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 31 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TODD AVE		d. STREET ADDRESS #1	
3. NAME OF DECEASED (Type or print) DAISY First B. SURRATT Middle Last		4. DATE OF DEATH Oct Month 6 Day 1960 Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 21 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Richard Johnson		14. MOTHER'S MAIDEN NAME Ella Bendall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? no (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. Suratt Address as in #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Acute Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular disease 15 yrs DUE TO (c) Cerebral Hemorrhage hemiplegia 11 yrs		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1945 , 19____, to Oct 6 , 19 60 , that I last saw the deceased alive on Sept 30 , 19 60 , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis N. Tollin		ADDRESS (Street, city or town, state) 6908 N. POINT RD. DATE SIGNED 10/6/60	
PHYSICIAN'S NAME (Type) LOUIS N. TOLLIN		BALTIMORE-19-MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 10, 1960	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.	22d. LOCATION (City, town, or county) (State) Washington Hvd. Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR OCT 11 '60 24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

111112

MARYLAND

CITY OF BALTIMORE

WARD 1

STREET 1

APARTMENT 1

ROOM 1

FLOOR 1

SECTION 1

LOT 1

BLK 1

TRCT 1

CD 1

PRECINCT 1

WARD 1

STREET 1

APARTMENT 1

ROOM 1

FLOOR 1

SECTION 1

LOT 1

BLK 1

TRCT 1

CD 1

PRECINCT 1

WARD 1

STREET 1

APARTMENT 1

ROOM 1

FLOOR 1

SECTION 1

LOT 1

BLK 1

TRCT 1

CD 1

PRECINCT 1

WARD 1

STREET 1

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11184

11167

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNT Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4206 Old North Point Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN F. TELMANOWSKI (TALMANOKY)		4. DATE OF DEATH 10 Month 24 Day 19 Year 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/1901
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deisel operator	11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Telmanowski	
14. MOTHER'S MAIDEN NAME Catherine Lysakowski		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.I	
16. SOCIAL SECURITY NO. 213-09-3733		17. INFORMANT Helen Telmanowski Address 4206 Old North Point	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior-Septal-Cardio-Vascular DUE TO Disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. Davis		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Weber & Sons Inc. ADDRESS 401 S. Chester St.		24a. REC'D BY REGISTRAR OCT 27 '60	
		24b. REGISTRAR'S SIGNATURE Guthrie S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



V5. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11168

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown, Md.		c. LENGTH OF STAY IN IB D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1 Cherry Hill Road		d. STREET ADDRESS 330 Tollgate Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GILBERT		First Middle Last S. THOMPSON		4. DATE OF DEATH Month Day Year Oct. 10 19 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1890	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY Gardening		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Thompson		14. MOTHER'S MAIDEN NAME Carrie Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address Mrs. Viola E. Thompson 330 Tollgate Road, Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none		(County) none		(State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-11-60	
EXAMINER'S NAME (Type) D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Balto. Co., Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-60		22c. NAME OF CEMETERY OR CREMATORY Family lot	
22d. LOCATION (City, town, or country) Johnsville, Md.		(State) Md.		24a. REC'D BY REGISTRAR DATE OCT 14 '60	
23. FUNERAL DIRECTOR Holland Funeral Home, Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Knead			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11185

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dth. No. 11169

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY 			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13yr8mth27dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1608 Carswell Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle C. Last Thrasher				4. DATE OF DEATH Month October Day 2 Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1904		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.		11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Clifton Thrasher				14. MOTHER'S MAIDEN NAME Eleanor Simmons P. Simmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-03-4831		17. INFORMANT Records, SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia <i>Pending</i> 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis Acute DUE TO (c) Fracture hip left							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks 26 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) At University Hospital (Brain softening, Chronic schizophrenia) Smith Peterson nailing with McGlaughlin attachment performed 8-18-60							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) At 4:30 a.m. on 8-6-60 pt. fell from bed, sustaining intertrochanteric frac. left femur.					
20c. TIME OF INJURY Hour 4:30 a.m. 8-6 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William E. McGrath</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 10-3-60	
EXAMINER'S NAME (Type) William E. McGrath, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-5-60		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd.				24a. REC'D BY REGISTRAR DATE OCT 7 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Bald 30

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11170

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 16 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY City - Balt. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk, d. STREET ADDRESS 2934 Yorkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT CLELLON THURMOND		4. DATE OF DEATH Month 10 Day 24 Year 19 60		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6/19/35 9. AGE (In years last birthday) 25 yrs. IF UNDER 1 YEAR Months 10 Days 24 IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- 10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Clellon Thurmond 14. MOTHER'S MAIDEN NAME Mildred Pearl Faught			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. --- 17. INFORMANT Rosewood State Training School Records Address ---		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia, acute 355X DUE TO Conditions, if any, which gave rise to immediate cause (b) --- (c) Chronic brain damage DUE TO since birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver					
20a. TIME OF INJURY Month, Day, Year Hour none e.m. 19 p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none			
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. (City or town) none		20f. (County) none			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples EXAMINER'S NAME (Type) D. D. Caples, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-25-'60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Horse Cave City Cemetery			
22d. LOCATION (City, town, or country) Horse Cave, Kentucky		23. FUNERAL DIRECTOR J.F.Eline & Sons, Reisterstown, Md.					
24a. REC'D BY REGISTRAR NOV 1 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines					

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

11188

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

11188

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11187

CERTIFICATE OF DEATH

11171
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3V 01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor for Aged & Conv.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle T. Last Tinsley		4. DATE OF DEATH Month Oct. Day 11 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 20, 1885
9. AGE (In years last birthday) yrs. 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Maintenance	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles L. Tinsley		14. MOTHER'S MAIDEN NAME Caroline W. Washum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-07-8240	
17. INFORMANT Barto G. Tinsley		Address 3424 Mayfair Rd. (7)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 to Oct. 11, 1960 , that I last saw the deceased alive on Oct. 9, 1960 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Nelson McKay		ADDRESS (Street, city or town, state) 6014 EDMONDSON AVE Balto 28, Md 10/11/60	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-1960	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong		24a. REC'D BY REGISTRAR Oct 17 '60	
ADDRESS 3207 W. North Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1113

PLACE OF DEATH Baltimore		COUNTY Baltimore	
STREET 2000 Forest Park Ave.		CITY Baltimore	
STATE Maryland		ZIP CODE 21204	
DECEASED John A. Tinsley		DATE OF DEATH 10-15-1961	
SEX Male		AGE 68	
RACE White		MARITAL STATUS Married	
OCCUPATION U.S. Army		CAUSE OF DEATH Myocardial Infarction	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH 10-15-1961	
SIGNATURE OF DECEASED John A. Tinsley		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]	

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11189

11173

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 129 Dihedral Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) S.A. WALTER FRANK First Middle Last UNVERZAGT UNVERZAGT				4. DATE OF DEATH Month October Day 5 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 19, 1892	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 7 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Augustus Unverzagt				14. MOTHER'S MAIDEN NAME Ida Cullerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 219-07-3121		17. INFORMANT Clinical Records, VAH Balto 18, Md., Ft Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) CORONARY INSUFFICIENCY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 Day UNKNOWN UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9/23 to 10/5 , that (I) (we) lost saw the deceased alive on 10/5/60 , and that death occurred at AM , from the causes and on the date stated above.							
22a. SIGNATURE Fredrick S. Donaldson				22b. DATE 10/5/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH Balto 18 Md Ft Howard Div.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				25a. REC'D BY REGISTRAR OCT 7 '60		25b. REGISTRAR'S SIGNATURE Carlton S. Knead	
25c. ADDRESS Wm Cook-Blight Inc 6009 Harford Rd Balto 14, Md							

11:18

CERTIFICATE OF DEATH

11:18



Form with multiple sections and fields, mostly illegible due to extreme fading. Visible text includes:

- Top section: "CERTIFICATE OF DEATH"
- Section 1: "Name of Deceased" (illegible)
- Section 2: "Date of Death" (illegible)
- Section 3: "Place of Death" (illegible)
- Section 4: "Cause of Death" (illegible)
- Section 5: "Signature of Physician" (illegible)
- Section 6: "Signature of Registrar" (illegible)
- Section 7: "Date of Registration" (illegible)
- Section 8: "Place of Registration" (illegible)
- Section 9: "Remarks" (illegible)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11190

11174

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 32yr 10mth					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Frank Middle Nicholas Last Vereker				4. DATE OF DEATH Month October Day 31 Year 1960					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22 1899			
9. AGE (In years last birthday) 61 yrs.		10. UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farming					
13. FATHER'S NAME James J. Vereker				14. MOTHER'S MAIDEN NAME Alice Kelly					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis DUE TO (c) Arteriosclerotic cardiovascular disease								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Spring Grove State Hospital				20g. (County) Catonsville		20h. (State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from July 1 19 60 , to Oct. 31 19 60 , that (I) (we) last saw the deceased alive on Oct. 31 19 60 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar				22b. DATE 11-1-60					
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) burial				23b. DATE THEREOF 7/3/60		23c. NAME OF CEMETERY OR CREMATORY St. Johns			
23d. LOCATION (City, town, or county) Long Green - Md				23e. (State) Md		23f. (Country) USA			
24. FUNERAL DIRECTOR'S SIGNATURE Stewart Morris - Balt. Md				25a. REC'D BY REGISTRAR Nov 3 '60		25b. REGISTRAR'S SIGNATURE Arthur E. Kenna			

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11174

CERTIFICATE OF DEATH

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DEATH
11174

CERTIFICATE OF DEATH

11175

Reg. Dist. No.

11191

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKDALE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3526 MILFORD MILL ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM KARL VOLLAND				4. DATE OF DEATH Month Day Year OCT. 4, 1960 19			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 24, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) FULLERTON, CANADA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM VOLLAND				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212 09 5275		INFORMANT 3526 MILFORD MILL ROAD MRS. ELIZABETH K. VOLLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Art. Sclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29th , 19 50 , to Oct 4th , 19 60 , that I last saw the deceased alive on Sept 30th , 19 60 , and that death occurred at 8:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James A. Miller M.D.				DATE SIGNED 10/5/60			
PHYSICIAN'S NAME (Type) James A. Miller M.D.				ADDRESS (Street, city or town, state) 1331 Reisterstown Rd Pikeville - Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/7/60		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) WOODLAWN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC.				24a. REC'D BY REGISTRAR OCT 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11175

11175



CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7906 Oakdale Rd</u>		e. STREET ADDRESS <u>7906 Oakdale Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George G Walter</u>		4. DATE OF DEATH Month Day Year <u>Oct 20 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 5 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis S. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Mollie M Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-2403</u>	
17. INFORMANT <u>George A Walter</u>		Address <u>7906 Oakdale Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerotic cardiovascular disease</u> DUE TO (c) <u>5-yr.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15 1959</u> to <u>10/20 1960</u> , that I last saw the deceased alive on <u>19/1960</u> , 19 <u>19</u> and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon Grau</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>19/60/60</u>	
PHYSICIAN'S NAME (Type) <u>Gordon Grau, M.D. 8523 Loch Raven Blvd, Balto. 4 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/24/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon PA</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Frank</u> ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11193

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11177

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 47 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUST Middle M Last WALTHER		4. DATE OF DEATH Month October Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph A. Walther		14. MOTHER'S MAIDEN NAME Elizabeth E. Rauck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 218-12-8345	
17. INFORMANT Clin. Rec. VAH Balto Md - Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE (c) MILD CARDIAC SCARRING		INTERVAL BETWEEN ONSET AND DEATH 8 hours Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mural Thrombosis, Old; Splenic Infarction, Recent		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that M (this hospital) attended the deceased from Sept. 14 8:15 to Oct. 31 1960 , that M (we) last saw the deceased alive on Oct. 31 1960 , and that death occurred at A. M. from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson		22b. DATE SIGNED 10/31/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, Fort Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE LEONARD J. RUCK		25a. REC'D BY REGISTRAR NOV 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

111194
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11178

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD VETERANS HOSP.		c. LENGTH OF STAY IN 1b 15 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 29	
		d. STREET ADDRESS 314 WESTOWNE ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle John Last WARD		4. DATE OF DEATH Month OCTOBER Day 21 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14 1892
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY SHEET METAL	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F WARD		14. MOTHER'S MAIDEN NAME EMMA ALBERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 213-34-1576	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) 190.9 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMIPARESIS			
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 6, 1960 to October 21, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 21 1960 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE ERNEST O. BROWN		22b. DATE SIGNED 10-21-60	
22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN		22d. ADDRESS M.D. VAH BALTO 18 MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/25/60	
23c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS Inc		25a. REC'D BY REGISTRAR OCT 24 '60	
ADDRESS North & Penna. Aves Baltimore, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

111195

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

111179

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle T Last WARD		4. DATE OF DEATH Month Oct Day 19 Year 1960	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/4/07
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WARD, Sr.		14. MOTHER'S MAIDEN NAME Emma Selby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mt. Wilson State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced Pulmo Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-7- 1960 , to 10-19 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-19-1960 , and that death occurred 12:45 PM on the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Oct. 23, 1960	
23c. NAME OF CEMETERY OR CREMATORY Stockton Cemetery		23d. LOCATION (City, town, or county) (State) Stockton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE NORMAN DENNIS		24. ADDRESS Snowhill, Md.	
25a. REC'D BY REGISTRAR OCT 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11196

CERTIFICATE OF DEATH

11180

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>	c. LENGTH OF STAY IN 1b <i>12 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paper Mill Road</i>		d. STREET ADDRESS <i>Paper Mill Road</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Clarence</i> Middle <i>Edward</i> Last <i>Waters</i>		4. DATE OF DEATH Month <i>October</i> Day <i>31</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9 April 1902</i>
9. AGE (In years lost birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>landscaping</i>	
11. BIRTHPLACE (State or foreign country) <i>Swatara Balto Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lawrence Waters</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ayers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-28-248</i>	
17. INFORMANT <i>wife - Same address</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of lower bowel</i> <i>153.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1950</i> to <i>October</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>29 Oct</i> , 19 <i>60</i> , and that death occurred at <i>2 NOON</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i>	
DATE SIGNED <i>31 October 1960</i>			
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>11/3/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. Zion</i>	22d. LOCATION (City, town, or county) (State) <i>Long Green, Balto Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Blumhagen</i>		ADDRESS <i>1701 McCall St. Balto Md.</i>	
24a. REC'D BY REGISTRAR <i>NOV 3 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knead</i>	

MEDICAL CERTIFICATION

TO HOSPITALS: 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11181

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Baltimore b. COUNTY Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN lb Box 445 Sunshine Rd.				d. STREET ADDRESS 304 3rd St. Overlea			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 445 Sunshine Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
JOSEPH		D. WEBSTER		OCTOBER		14 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1908	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George R. Webster				14. MOTHER'S MAIDEN NAME Florence Bramble			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216035172		17. INFORMANT Elaine Webster		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastasis. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		October 14, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-17-60	22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or country) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Rd.				24a. REC'D BY REGISTRAR OCT 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

111198
111182
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Purvis Place				d. STREET ADDRESS 204 Purvis Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARCUS Middle HESS Last WEIL				4. DATE OF DEATH Month Oct. Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Moses Weil				14. MOTHER'S MAIDEN NAME Sarah Hess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Nettie Weil-204 Purvis Place-Pikesville				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) atherosclerotic heart disease DUE TO (b) few yrs. Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mixed tumor of rt. parotid gland removed 5 Oct 60 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1958 , 19____, to 26 Oct, 1960 , that I last saw the deceased alive on 26 Oct, 1960 , and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1403 Foley Lane Baltimore, Maryland DATE SIGNED 27 Oct 60 ACTUAL SIGNATURE Paul H Royse M.D. 1403 Foley Lane PHYSICIAN'S NAME (Type) Paul H Royse MD Pikesville 8 Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/60		22c. NAME OF CEMETERY OR CREMATORY Oheb Shalom Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker ADDRESS 17, Md. North & Palmer Balto							
24a. REC'D BY REGISTRAR DATE OCT 28 '60				24b. REGISTRAR'S SIGNATURE William S. Hanks			

MEDICAL CERTIFICATION

10

2

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				11183	
11199				CERTIFICATE OF DEATH	
Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESACO</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESACO PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8415 OLD PHILA ROAD</u>		d. STREET ADDRESS <u>8415 OLD PHILA ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>A</u> Last <u>WIEGAND</u>		4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>DEC 10, 1897</u>		9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JOHN BOHLEN</u>		14. MOTHER'S MAIDEN NAME <u>MARY E MOHR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>MARIE LAUBACH 8415 OLD PHILA RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic Cardio-Vascular disease</u> DUE TO (c) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>60</u> , to <u>Oct 6</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>60</u> and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J M Baumgardner M.D.</u>		ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>		DATE SIGNED <u>10/9/60</u>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 10, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ZION LUTHERAN</u>	
22d. LOCATION (City, town, or county) (State) <u>Stemmers Run Md. Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd #6</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Knaus</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>OCT 14 '60</u>			

1991.01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11200

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12390

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vet. Adm. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT First WILLIAMS, JR. Middle Last		4. DATE OF DEATH October 29 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1924
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Fayetteville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Williams, Sr.		14. MOTHER'S MAIDEN NAME Flora McPherson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. PL-28K 0846-10-3634	
17. INFORMANT Clin. Rec. VAH, Baltimore, Md. Fort Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HODGKIN'S DISEASE (c) HEMORRHAGIC DIATHESIS DUE TO DG.# 2		INTERVAL BETWEEN ONSET AND DEATH 6 hours 2 years 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from Oct. 21 1960 to Oct. 29 1960 , that 10 (we) last saw the deceased alive on Oct. 29 1960 , and that death occurred at 1:30 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Norman P. Jones		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) NORMAN P. JONES, M.D.		22d. ADDRESS VAH, Baltimore 18, Md. Ft. Howard Div.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR DATE NOV 9 '60	
ADDRESS 1808 N. Monroe St. Balto. 17, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
11201

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11184

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orings Mills		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) First Mark Middle Evan Last WINCHESTER		4. DATE OF DEATH Month 10 Day 20 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/60
9. AGE (In years last birthday) -- yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 17 Days 17 Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Jennings Winchester, Jr.		14. MOTHER'S MAIDEN NAME BLACKMON, Valinda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Rosewood records		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status epilepticus DUE TO 750X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anencephaly with encephalocele - occipital DUE TO --- (c) ---		INTERVAL BETWEEN ONSET AND DEATH since birth since birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 17 to Oct. 20 19 60 , that (I) (we) last saw the deceased alive on Oct. 20 19 60 and that death occurred at 3:10 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Harry G. Butler, M.D.		22b. DATE SIGNED 10/21/60	
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		22d. ADDRESS Rosewood State Training School, Cwings	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/60	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR 24 '60	
ADDRESS 4905 York Rd 12		25b. REGISTRAR'S SIGNATURE Wm. A. Thoms	

2042 22 2XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be recorded by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11202

11185

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 21 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle E. Last WISNER		4. DATE OF DEATH Month OCTOBER Day 17 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/11
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Rayville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Wisner		14. MOTHER'S MAIDEN NAME Ida Still	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 180-09-4249	
17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE ORAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) EPIDERMOID CARCINOMA OF THE TONGUE WITH METASTASIS DUE TO TO CERVICAL LYMPH NODES (c) EDEMA OF LUNGS		INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from Sept. 26 1960 to Oct. 17 1960 , that I (we) last saw the deceased alive on October 17 1960 , and that death occurred at 12:20 PM on the causes and on the date stated above.			
22a. SIGNATURE Joshua D. Smith		22b. DATE SIGNED 10/17/60	
22c. PHYSICIAN'S NAME (Type) JOSHUA SMITH, M.D.		22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY Stablers Cemetery		23d. LOCATION (City, town, or county) (State) Parkton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein, New Freedom, Pa.		25a. REC'D BY REGISTRAR OCT 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11502

CERTIFICATE OF DEATH

11502

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CHIEF JAMES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11203 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11186

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3350 Strickland Street,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL L. WOODY				4. DATE OF DEATH Month Day Year October 4 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 27, 1897	
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Material Handler		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John D. Woody				14. MOTHER'S MAIDEN NAME Margaret M. Davidson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 213-05-2955		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 429-0 (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH 1 DAY			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 30, 1960 to October 4, 1960 , that (X) (we) last saw the deceased alive on October 4, 1960 , and that death occurred at 8:35 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE 10/4/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION				22e. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE St. Gorman Schwal				25a. REC'D BY REGISTRAR DATE OCT 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

3512 Fred. Ave. - 29-

11136

CERTIFICATE OF DEATH

11503

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11204

CERTIFICATE OF DEATH

11187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4 (Towson)</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>619 Hillen Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson, Baltimore 4 Md. 55</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EDWARD</u> Last <u>YEAPLE</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 8, 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eastman Kodak</u>	
11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm.H. Yeaple</u>		14. MOTHER'S MAIDEN NAME <u>Ingeborg Berry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-2569</u>	
17. INFORMANT <u>Mrs. Marion K. Yeaple</u>		Address <u>619 Hillen Rd. 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung-Rt.</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>60</u> , to <u>Oct 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>60</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		ADDRESS (Street, city or town, state) <u>6805 York Rd Baltimore 12 Md</u>	
DATE SIGNED <u>10/10/60</u>			
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill York, Pa.</u>		22d. LOCATION (City, town, or county) (State) <u>York, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.</u>		ADDRESS <u>1050 York Rd. Towson</u>	
24a. REC'D BY REGISTRAR <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11205

CERTIFICATE OF DEATH

Reg. Dist. No.

11188

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 20 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6419 Murray Hill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frances T. Young		4. DATE OF DEATH Month Day Year October 13, 1960.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1877
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael C. Gunning		14. MOTHER'S MAIDEN NAME Elizabeth C. Pierce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Edward T. Young		Address 405 Meadow Rd. (6)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 443X DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) person DUE TO (c) person		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema due to Cardiac Decompensation			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 4, 1940 to Oct 13, 1960 that I last saw the deceased alive on Oct 12, 1960 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10/14/60 DATE SIGNED			
ACTUAL SIGNATURE Lester N. Kolman		M.D. 10/14/60	
PHYSICIAN'S NAME (Type) LESTER N. KOLMAN, M.D.		3700 Park Heights Avenue	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1960	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W. North Ave	
24a. REC'D BY REGISTRAR OCT 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11206
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11189

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2mth6dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1844 West Baltimore St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle M Last Zayenkauskas				4. DATE OF DEATH Month 10 Day 9 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1885	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailoring				10b. KIND OF BUSINESS OR INDUSTRY tailoring Co.		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? Lithuania ✓							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. 213-09-9129		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BACTEREMIA FROM MULTIPLE DECUBITUS DUE TO 715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERAL DEBILITY DUE TO (c) GENERAL DEBILITY				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1960 to OCT 9, 1960 , that (I) (we) last saw the deceased alive on OCT. 9, 1960 , and that death occurred at 220 PM , from the causes and on the date stated above.							
22a. SIGNATURE P. K. Yon Yip				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 10/9/60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) P. K. Yon Yip				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/13/60		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City, town, or county) (State) 4430 Belair Rd Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Cavanaugh				ADDRESS Hollis St.		25a. REC'D BY REGISTRAR DATE OCT 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11123

CENTRAL OF DEATH

11503



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "DEATH" and "CENTRAL" are visible.]

VS A15 (4)
15M 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11207

CERTIFICATE OF DEATH

11190
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 414 Frederick Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last ZENTER		4. DATE OF DEATH Month Oct. Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 4 Days 20	11. IF UNDER 24 HRS. Hours 4 Min. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Montgomery Co. Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Burriss		14. MOTHER'S MAIDEN NAME Mary Elizabeth Cracroft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Dudley Zenter, 414 Frederick Road, Ellicott City		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-1 Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. myocarditis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 60 , to Oct 19 , 19 60 , that I last saw the deceased alive on Oct 18 , 19 60 , and that death occurred at 10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Taylor		ADDRESS (Street, city or town, state) 111 Columbia Rd Ellicott City Md	
PHYSICIAN'S NAME (Type) Robert B. Taylor		DATE SIGNED 10-20-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-60	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Rockville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS	
24a. REC'D BY REGISTRAR Oct 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. [unclear]	

